

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4** may be returned by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Randolph Hills Nursing home</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Peter</b>			First	Middle	Last
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/27/1880</b>	9. AGE (In years last birthday) <b>87</b> yrs.	4. DATE OF DEATH <b>DEC 28 1967</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>N. Y.</b>		
13. FATHER'S NAME <b>Isaac Addis</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>043-26-4227</b>	17. INFORMANT <b>Wife</b> <b>Beatrice Addis</b>	Address <b>Same as Item 2.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Upper respiratory infection viral + possibly bacterial.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>475x</b>					
DUE TO (b) <b>possibly bacterial.</b>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Arteriosclerotic heart disease</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Montgomery</b>	(County) <b>Maryland</b> (State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 26, 1967</b> , to <b>Dec 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 8, 1967</b> , and that death occurred at <b>8 P.M.</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>A.J. Connally</b>			M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-28-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.J. CONNALLY</b>			22d. ADDRESS <b>1635 IRVINE ST. X-66 Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-30-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>	23d. LOCATION (City or Town) <b>Silver Spring</b> (County) <b>Montgomery</b> (State) <b>MD</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		ADDRESS <b>7557 Wisconsin Ave</b>	25a. REC'D BY REGISTRAR <b>Charles George</b>	25b. REGISTRAR'S SIGNATURE <b>Charles George</b>	



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CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Virginia</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Virginia Beach</b>			d. STREET ADDRESS <b>312 Hospital Drive</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Jacqueline</b>	Middle <b>Lois</b>	Last <b>Akers</b>	4. DATE OF DEATH <b>December 5 1967</b>	Month <b>December</b>	Doy <b>5</b>	Year <b>1967</b>	IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS. Days <b>8 yrs.</b>	IF UNDER 24 HRS. Hours <b>0</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12 July 1959</b>	9. AGE (In years lost birthday) <b>8 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Wayne J. Akers</b>						14. MOTHER'S MAIDEN NAME <b>Lois V. Hall</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:  <b>Respiratory Insufficiency</b>  <span style="margin-left: 20px;">IMMEDIATE CAUSE (a)</span>  <span style="margin-left: 20px;">DUE TO</span>  <span style="margin-left: 40px;">(b) Acute Pneumonia</span>  <span style="margin-left: 20px;">DUE TO</span>  <span style="margin-left: 40px;">(c) Cystic Fibrosis of the Pancreas</span> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b></p>											
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Norfolk</b>	(County) <b>Virginia</b>	(State) <b>Virginia</b>		
<p>21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 1, 1967</b> to <b>Dec. 5, 1967</b>, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 5, 1967</b>, and that death occurred at <b>9:43 AM</b>, from causes and on the date stated above.</p> <p>22. SIGNATURE <b>Stuart Handwerger</b></p> <p>22b. DATE SIGNED <b>5 December 1967</b></p>											
22c. PHYSICIAN'S NAME (Type)		<b>Stuart Handwerger, MD</b>			22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>12/8/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Forest Lawn Cemetery</b>			23d. LOCATION (City or Town) <b>Norfolk, Virginia</b>			(County) <b>Virginia</b>	(State) <b>Virginia</b>
24. FUNERAL DIRECTOR		ADDRESS <b>Simiele Funeral Home Va. Beach, Va.</b>			25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>			

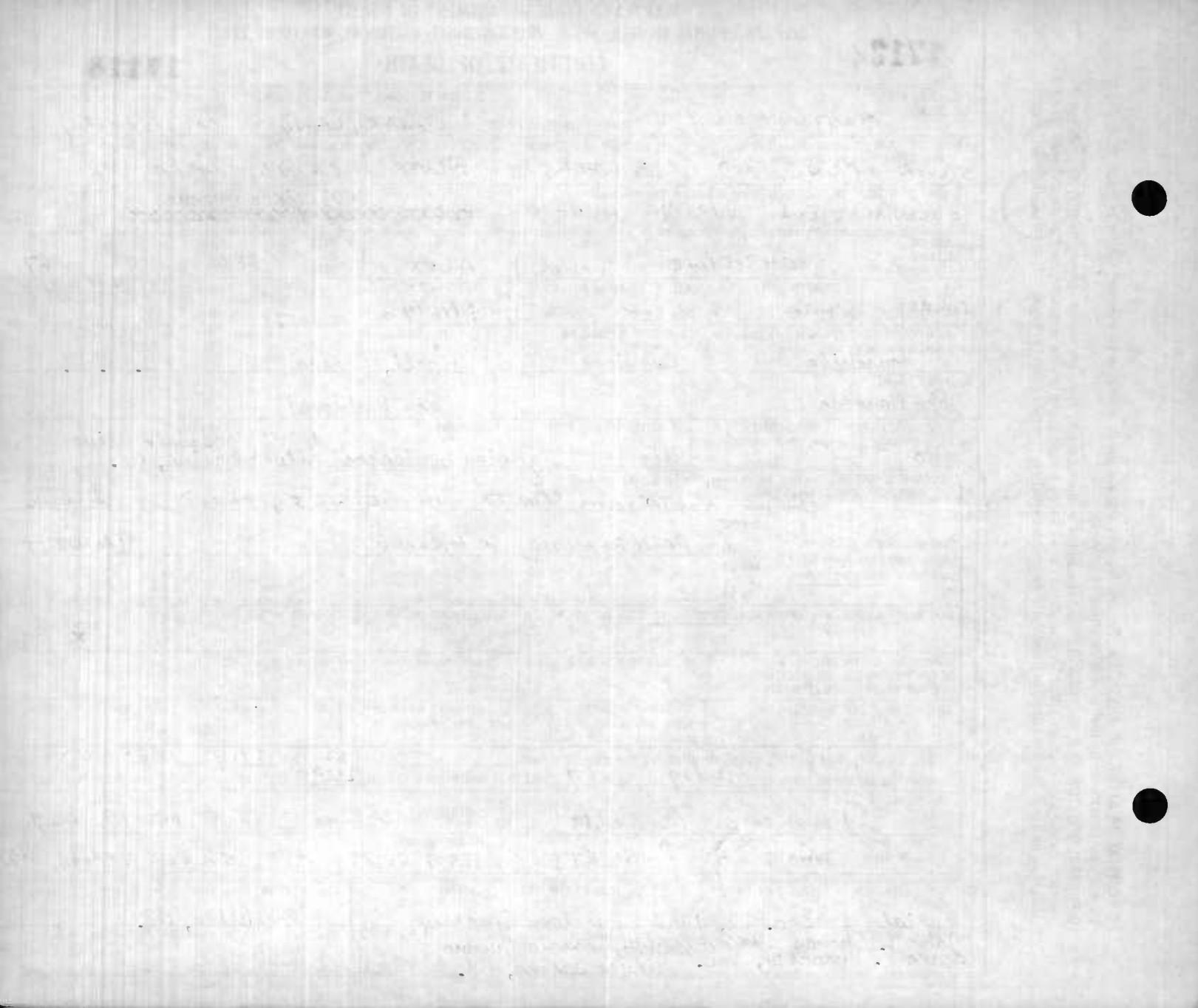


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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file death certificate with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MD.			c. LENGTH OF STAY IN lb 3 WEEKS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MARYLAND 15-1			d. STREET ADDRESS 8403 Dixon Avenue Rockville Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COLONIAL VILLA NURSING HOME						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First CHRISTINE	Middle (NONE)	Lost	ALEX	4. DATE OF DEATH	Month DEC.	Doy 19	Year 1967		
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/16/96	9. AGE (In years lost birthday) yrs. 71		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Trinoli, Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Manetas						14. MOTHER'S MAIDEN NAME Mary (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. Yes	17. INFORMANT Helen Sanidakes		Address 10702 Woodsdale Drive Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CANCER IN LUNGS, CAUSE? 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) PANCREATITIS, CHRONIC DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____, 1962, to 12/19, 1967, that (I/we) last saw the deceased alive on 12/19 1967, and that death occurred at 1230 P.M. from causes and on the date stated above.											
22a. SIGNATURE James A. Roberts						22b. DATE SIGNED DEC. 19, 1967					
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS 8907 GEORGIA AVE. SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 22, 1967			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville Md		
24. FUNERAL DIRECTOR John E. Thomas, Huber Warner E. Humphrey, Inc.			ADDRESS 8907 Georgia Avenue Silver Spring, Md.			25a. REC'D BY REGISTRAR DEC 27 1967			25b. REGISTRAR'S SIGNATURE James A. Roberts		



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17123 17119 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>18 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4120 Stanford St</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Montgomery</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> h. STREET ADDRESS <b>4120 STANford St</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Samuel Nathan Alexander</b>			First <b>S</b> , Middle <b>N</b> , Last <b>Alexander</b>	4. DATE OF DEATH <b>12 9 1967</b>	Month <b>12</b> , Day <b>9</b> , Year <b>1967</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 22, 1910</b>	9. AGE (In years last birthday) <b>57 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>electrical engineer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Gov.t.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Wharton, Texas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Max Alexander</b>			14. MOTHER'S MAIDEN NAME <b>Minnie Smith</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>013-05-6897</b>	17. INFORMANT <b>Mrs. Eleanor Alexander</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Stomach</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>		
DUE TO (b) <b></b> DUE TO (c) <b></b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>March 1963</b> , to <b>Dec 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 8, 1967</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.
21. I certify that (I) (this hospital) attended the deceased from <b>March 1963</b> , to <b>Dec 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 8, 1967</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			22a. SIGNATURE <b>William Harvey</b>		
22b. DATE SIGNED <b>12/9/67</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>2121 Penn Ave N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/11/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>King David Memorial Park</b>	23d. LOCATION (City, town or county) (State) <b>Falls Church, Virginia</b>
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.			ADDRESS <b>5130 Wisconsin Ave. N.W. Washington, D.C.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
VR A15 (4) 15M 4-64			DATE <b>DEC 15 1967</b>		

2720 ~~1~~ ~~2~~ ~~3~~ ~~4~~ ~~5~~ ~~6~~ ~~7~~ ~~8~~ ~~9~~ ~~10~~ ~~11~~ ~~12~~ ~~13~~ ~~14~~ ~~15~~ ~~16~~ ~~17~~ ~~18~~ ~~19~~ ~~20~~ ~~21~~ ~~22~~ ~~23~~ ~~24~~ ~~25~~ ~~26~~ ~~27~~ ~~28~~ ~~29~~ ~~30~~ ~~31~~ ~~32~~ ~~33~~ ~~34~~ ~~35~~ ~~36~~ ~~37~~ ~~38~~ ~~39~~ ~~40~~ ~~41~~ ~~42~~ ~~43~~ ~~44~~ ~~45~~ ~~46~~ ~~47~~ ~~48~~ ~~49~~ ~~50~~ ~~51~~ ~~52~~ ~~53~~ ~~54~~ ~~55~~ ~~56~~ ~~57~~ ~~58~~ ~~59~~ ~~60~~ ~~61~~ ~~62~~ ~~63~~ ~~64~~ ~~65~~ ~~66~~ ~~67~~ ~~68~~ ~~69~~ ~~70~~ ~~71~~ ~~72~~ ~~73~~ ~~74~~ ~~75~~ ~~76~~ ~~77~~ ~~78~~ ~~79~~ ~~80~~ ~~81~~ ~~82~~ ~~83~~ ~~84~~ ~~85~~ ~~86~~ ~~87~~ ~~88~~ ~~89~~ ~~90~~ ~~91~~ ~~92~~ ~~93~~ ~~94~~ ~~95~~ ~~96~~ ~~97~~ ~~98~~ ~~99~~ ~~100~~ ~~101~~ ~~102~~ ~~103~~ ~~104~~ ~~105~~ ~~106~~ ~~107~~ ~~108~~ ~~109~~ ~~110~~ ~~111~~ ~~112~~ ~~113~~ ~~114~~ ~~115~~ ~~116~~ ~~117~~ ~~118~~ ~~119~~ ~~120~~ ~~121~~ ~~122~~ ~~123~~ ~~124~~ ~~125~~ ~~126~~ ~~127~~ ~~128~~ ~~129~~ ~~130~~ ~~131~~ ~~132~~ ~~133~~ ~~134~~ ~~135~~ ~~136~~ ~~137~~ ~~138~~ 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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17120

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MD.		c. LENGTH OF STAY IN lb 2½ hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENNSINGTON			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL				d. STREET ADDRESS 3229 University Blvd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First AHMED		Middle		Lost ALHASHIMI		4. DATE OF DEATH	Month 12 Doy 12 Year 1967
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/17/62	9. AGE (In years last birthday) 5 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IRAQ	
13. FATHER'S NAME KHALID ALHASHIMI				14. MOTHER'S MAIDEN NAME unobtainable			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. A. Youssef - Kensington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812.4 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c) DUE TO				Multiple extreme Injuries including fractured skull and cerebral laceration			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child ran onto street in front of auto and was struck			
20c. TIME OF INJURY Month, Day, Year Nov 12 1967				20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				20f. (City or town) (County) (State) Kensington, Montgomery, Md.			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, town, county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 12/14/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS National Mem. Park	
24. FUNERAL DIRECTOR The H. Hines Co.				23d. LOCATION (City or Town) (County) (State) Falls Church, Va.		25a. REC'D BY REGISTRAR DATE DEC 15 1967	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17125

CERTIFICATE OF DEATH

17121

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
c. LENGTH OF STAY IN lb			d. STREET ADDRESS <u>2411 Darrow Street</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED First <u>HAZEL</u> Middle <u>WURENE</u> Last <u>ALLEN</u> (Type or print)			4. DATE OF DEATH Month <u>Dee.</u> Day <u>27</u> Year <u>1967</u>		
S. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1899</u>	9. AGE (In years last birthday) <u>67 yrs.</u>	IF UNDER 1 YEAR Months <u>Days</u> Hours <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <u>Christiansburg, Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Noah Cole</u>			14. MOTHER'S MAIDEN NAME <u>Annie (Unknown)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>578-07-5110</u>		
17. INFORMANT <u>A Thomas J. Allen Silver Spring, Md.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u>			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Cerebral hemorrhage</u> (c) <u>Hypertension</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>p.m.</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>12/27</u> , 1967, that (we) lost saw the deceased alive on <u>12/27 1967</u> , and that death occurred at <u>3A</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Norman H. Rubenstein</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12/27/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein</u>		22d. ADDRESS <u>11161 New Hampshire Avenue, S. S. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Charles Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave.</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25. SIGNATURE <u>C. Glen Carter</u>		Spouse <u>Silver Spring, Md.</u>	DATE <u>JAN 4 1968</u>		

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BUSINESS SCHOOL

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours of death.

17126

CERTIFICATE OF DEATH

17122

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE					
Montgomery MARYLAND		Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY					
Silver Spring	7 Months	Montgomery					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Colonial Villa Nursing Home	Silver Spring						
90		d. STREET ADDRESS					
		702 Venice Drive					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month Day Year					
3. NAME OF DECEASED (Type or print)		First	Middle				
Gertrude BELLE Andrews		Lost	12 5 1967				
4. SEX		5. COLOR OR RACE	6. MARRIED				
F		White	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				
7. MARRIED		8. DATE OF BIRTH					
		SEPT. 20, 1871					
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					
96 yrs.		Housewife					
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Ohio		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Unknown		Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <i>If yes give war or dates of service</i>		16. SOCIAL SECURITY NO.					
No 218-54-5076		218-54-509684					
17. INFORMANT		Address					
Daughter - Mrs. Thos. Perkins		702 Venus Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		? 1 year					
443X Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Due to } (c)		Cardiac Decompensation Arteriosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		? Hypertension					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
19							
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____ and that death occurred at _____ M. from causes and on the date stated above.		22b. DATE SIGNED 12/5/67					
22a. SIGNATURE <i>William Andrews</i>		M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) William D. Andrews		22d. ADDRESS 9006 Colesville Rd Silver Spring MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIALy	23d. LOCATION (City or Town)		(County)	(State)
Burial		12/7/1967	George Washington Cem.	Ric's Rd		Transvaal Rd	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge		
W.W. Chambers, Inc. Silver Spring, MD.				DEC 7 1967			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17123

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roxbury</u> . c. LENGTH OF STAY IN lb <u>18 Months</u> .				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> . b. COUNTY <u>Dutchess</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cetra Hall Nursing Home.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Red Hook.</u>			
3. NAME OF DECEASED First <u>Adelaide</u> Middle <u>Elting</u> Last <u>Arnold.</u>				4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1967</u>			
S. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1882</u>	9. AGE (In years last birthday) <u>85 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Honore.</u>	11. BIRTHPLACE (State or foreign country) <u>New York.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>Henry S. Elting</u>				14. MOTHER'S MAIDEN NAME <u>Sara J. Pitcher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>			16. SOCIAL SECURITY NO. <u>123-45-6789</u>	17. INFORMANT <u>Elting-Arnold. 4919 Dorset Ave. Bronx, N.Y.</u>	Address <u>Cherry Hill Apartments</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u> (b) <u>Cardio-Vascular Disease -</u> (c)				INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Hudson Park</u> (County) <u>New York</u> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>BETHESDA, MD.</u>		12/30/67.					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-3-68</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>St James Cemetery</u>	23d. LOCATION (City) <u>Hudson Park</u> (County) <u>New York</u> (State)	22. DATE SIGNED			
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>	25a. ADDRESS <u>7557 Wisconsin Ave</u> <u>Bethesda, Md</u>	25b. REC'D BY REGISTRAR <u>DADAN</u> <u>5 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

OVA. B. 1900. 1. 1. 1927

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17128

## CERTIFICATE OF DEATH

17124

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>26 years</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>9210 Flower Avenue</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>9210 Flower Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Rosalind</i>		First <i>Moore</i>	Middle <i>Bain</i>
4. DATE OF DEATH <i>December 13, 1967</i>		Month <i>December</i>	Day Year <i>20 1967</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec. 13, 1869</i>		9. AGE (In years last birthday) <i>98 yrs.</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dentist</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i>	
13. FATHER'S NAME <i>Joseph B. Moore</i>		14. MOTHER'S MAIDEN NAME <i>Amelia H. Prettyman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>David P. Moore</i>	
17. INFORMANT <i>9210 Flower Avenue</i>		Address <i>Silver Spring, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several hours</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized arterio sclerosis</i>		DUE TO (b) DUE TO (c)	
DUE TO (b) DUE TO (c)		Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>9301 Colesville Rd., Silver Spring, Md.</i>
20f. (City or town) <i>9301 Colesville Rd., Silver Spring, Md.</i>		(County) <i>Prince Georges Co., Md.</i>	
		(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> , to <i>December 20, 1967</i> , that (I) (we) last saw the deceased alive on <i>December 20, 1967</i> , and that death occurred at <i>9:00 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>December 20, 1967</i>	
22a. SIGNATURE <i>Bennet A. Porter, Jr., M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Bennet A. Porter, Jr., M.D.</i>		22d. ADDRESS <i>9301 Colesville Rd., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Entombment</i>		23b. DATE THEREOF <i>Dec. 23, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Mausoleum</i>
24. FUNERAL DIRECTOR <i>John B. Thomas</i> <i>Warren E. Lumpkin, Inc.</i>		23d. LOCATION (City or Town) <i>Prince Georges Co., Md.</i>	(County) <i>Prince Georges Co., Md.</i>
		25a. ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>	(State) <i>Md.</i>
		25a. REC'D BY REGISTRAR <i>DEC 27 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>

221

222

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17129		17123	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>2 mos.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Potomac Valley Nursing Home Potomac</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. 3. NAME OF DECEASED (Type or print) <i>First: Delia Ferrari Middle: Baldaccini</i>		4. DATE OF DEATH <i>Month: 12 Doy: 14 Year: 1967</i>	
g. SEX <i>F</i>		h. COLOR OR RACE <i>W</i>	
i. 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		j. 8. DATE OF BIRTH <i>9-24-1882</i>	
k. 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		l. 10b. KIND OF BUSINESS OR INDUSTRY <i>- - - - -</i>	
m. 13. FATHER'S NAME <i>Carlo Ferrari</i>		n. 11. BIRTHPLACE (County & State, or foreign country) <i>Italy</i>	
o. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		p. 16. SOCIAL SECURITY NO. <i>578-68-7321-51</i> q. 17. INFORMANT <i>Keo Goss-Daughter- See Item No. 9</i> r. Address	
s. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>334 X</i> DUE TO <i>Cerebral Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized Atherosclerosis</i>		t. INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
u. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		v. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
w. 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		x. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
y. 21. I certify that (I) (this hospital) attended the deceased from <i>Oct 17</i> , 1967 to <i>Dec 14</i> , 1967, that (I) (we) last saw the deceased alive on <i>Nov 19</i> , 1967, and that death occurred at <i>132</i> M, fram causes and on the date stated above.		z. 22a. SIGNATURE <i>Robert Macon</i>	
aa. 22c. PHYSICIAN'S NAME (Type)		ab. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> cc. DATE SIGNED <i>12/14/67</i>	
dd. 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		ee. 23b. DATE THEREOF <i>12-16-1967</i>	
ff. 24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		gg. ADDRESS <i>5130 Wisconsin Ave. N.W. Washington, D.C.</i>	
hh. 25a. REG'D BY REGISTRAR <i>DEO 10 1967</i>		ii. 25b. REGISTRAR'S SIGNATURE <i>Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

*17130*  
- *deceased with medical garnish*

<b>CERTIFICATE OF DEATH</b>												<i>17126</i>			
1. PLACE OF DEATH <b>Montgomery County Maryland</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>						a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>						c. LENGTH OF STAY IN lb. <b>1 hr. 20 min.</b>						b. COUNTY <b>PR. GEORGE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash San + Hosp.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First <b>EVA</b>	Middle		Last <b>BALDWIN</b>	Month <b>12</b>	Day <b>27</b>	Year <b>1967</b>						
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>1893</b> <b>3-27-1893</b>						9. AGE (In years lost birthday) <b>74 95 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Canada</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Thomas Martell</b>						14. MOTHER'S MAIDEN NAME <b>Amanda Tourpin</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-56-2421</b>				17. INFIRMANT <b>Martha Petrone - dg</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Hypertension &amp; arteriosclerosis CVD.</b>												INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1955, 19</b>		(County) <b>12-27, 1967</b>		(State)			
21. I certify that <b>D</b> (this hospital) attended the deceased from <b>1955, 19</b> to <b>12-27, 1967</b> , that <b>G</b> (we) last saw the deceased alive on <b>12-27 1967</b> , and that death occurred at <b>12-27-67</b> from causes and on the date stated above.															
22a. SIGNATURE <i>R.D. Bauer MD</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>12-27-67</b>							
22c. PHYSICIAN'S NAME (Type) <b>R.D. BAUER, M.D.</b>				22d. ADDRESS <b>2513 Buck Lodge Rd. Beltsville Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12/30/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland, Md.</b>		(County)		(State)			
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>				ADDRESS <b>Mt. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>							

1967

2000



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17131

## CERTIFICATE OF DEATH

17127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>MONTGOMERY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross</i>		d. STREET ADDRESS <i>10104 BURNETT AVE.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HARRY</i>		First	Middle	Last	4. DATE OF DEATH December 8, 1967	Month	Year Day 8, Year 1967
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>3/10/198</i>	9. AGE (In years last birthday) <i>69</i>	IF UNDER 1 YEAR Months <i>6</i>	IF UNDER 24 HRS. Days <i>9</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETAILER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>GROCER</i>		11. BIRTHPLACE (County & State, or foreign country) <i>WASH. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>	
13. FATHER'S NAME <i>MORRIS</i>		14. MOTHER'S MAIDEN NAME <i>LEAH</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-07-8425</i>	
17. INFORMANT <i>Martin Baltrotsky</i>		Address <i>1801 Arcola Ave. Silver Spring,</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Papillary neoplasia</i> DUE TO <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diuretic therapy</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 4, 1967</i> , to <i>Dec 8, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 8, 1967</i> , and that death occurred at <i>3:00 PM</i> , from causes and on the date stated above.		22a. SIGNATURE <i>B. Stein</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22b. DATE SIGNED <i>12/9/1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>BLAINE H. STEIN</i>		22d. ADDRESS <i>8641 Coleridge Rd, Silver Spring, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 10, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>King David Memorial Garden</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Virginia</i>	
24. FUNERAL DIRECTOR <i>Donald M. Stein</i>		ADDRESS <i>232 Carroll St., N.W.-Wash., D.C.</i>		25a. REC'D BY REGISTRAR <i>DATE</i>		25b. REGISTRAR'S SIGNATURE <i>Blanche Judge</i>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

## **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17128

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Takoma Park</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN lb Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>7333 New Hampshire Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>				4. DATE OF DEATH Month <b>12</b> Year <b>1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ernest</b>		First <b>E</b>	Middle <b>P.</b>	Last <b>Barbour</b>		Doy <b>25</b>	Year <b>1967</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1910</b> 5/25/1910	9. AGE (In years last birthday) <b>57 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Doy <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt. Prtg. Office</b>		11. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip J. Barbour</b>		14. MOTHER'S MAIDEN NAME <b>Ida G. Turner</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWII</b>		16. SOCIAL SECURITY NO. <b>216-44-9552</b>		17. INFORMANT <b>Mrs. Mary Bennett - Sister-in-Law</b>		Address <b>7300-Birch Ave., Tak.Pk., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>8194</b> DUE TO (b) <b>Multiple Extreme Internal Injuries with Exsanguination</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18. <b>Deceased, driver, hit median strip lost control of car &amp; struck pole</b>		20c. TIME OF INJURY Month, Doy, Year <b>10:30 a.m. 12-24-1967</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Hyattsville</b>		20g. (County) <b>B. Co., Md.</b>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>DEC. 25, 1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier, Maryland</b>		35a. REC'D BY REGISTRAR <b>JAN 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Johns Jrge</b>	

Picture 1 -

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Indicates that the 2000 ft. contour is at the same elevation as the 1000 ft.

CS 21 - 2000

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**CERTIFICATE OF DEATH**

17129

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 58 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas		d. STREET ADDRESS 251 King George Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marion		First	Middle Carlton	Lost	4. DATE OF DEATH December 13	Month 19	Doy 67 Year
S. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jul. 15, 1921	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Dofs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Eureka, North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leslie Norman Barnes				14. MOTHER'S MAIDEN NAME Eva Strother			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes 1942-1967		16. SOCIAL SECURITY NO. 240 01 1458		17. INFORMANT Manassas Address Mrs. Nancy J. Barnes, 251 King George Dr.		Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic necrosis massive, with bleeding 583X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO diathesis (b) _____ DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Idiopathic thrombocytopenic purpura				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from Oct. 16, 1967, to Dec. 13, 1967, that (s) (we) last saw the deceased alive on Dec. 13, 1967, and that death occurred at 855A M, from causes and on the date stated above.							
22a. SIGNATURE Ross B. Moquin				M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Ross B. Moquin, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/67		23c. NAME OF CEMETERY OR CREMATORIUM Stonewall Memory Gardens		23d. LOCATION (City or Town) (County) (State) Manassas, Virginia	
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 West Broad Street, Falls Church, Virginia				ADDRESS		25a. RECEIVED BY REGISTRAR DEC 18 1967	25b. REGISTRAR'S SIGNATURE Charles Juge

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>D. C.</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>620 Princeton Place, N. W.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Elmore</b>		First	Middle	Lost	4. DATE OF DEATH <b>December 2</b>	Month	Doy	Year
S. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <b>WIDOWED</b>	NEVER MARRIED <b>Divorced</b>	B. DATE OF BIRTH <b>2/18/1886</b>	9. AGE (In years lost birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Massies Mill, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Barnett</b>		14. MOTHER'S MAIDEN NAME <b>Sylvia Barnett</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-60-5899</b>		17. INFORMANT - <b>Wife</b> - <b>Loretta Barnett</b>		Address <b>620 Princeton Pl N Wash, D.C.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>CVA</b> 33 IX		DUE TO (b) <b>Cerebral arteriosclerosis</b>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.      19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 20, 1967</b> , to <b>December 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>November 28, 1967</b> , and that death occurred at <b>2 P.M.</b> , from causes and on the date stated above.								
22a. SIGNATURE <i>Myron Lenkin</i>		22b. DATE SIGNED <b>December 2, 1967</b>						
22c. PHYSICIAN'S NAME (Type) <b>Myron Lenkin</b>		22d. ADDRESS <b>University Nursing Home</b> <b>Wheaton, Md</b>						
23a. BURIAL, CREMATION, BURNAWAY (City) <b>Burial</b>		23b. DATE THEREOF <b>12/6/1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Harmony MEM Cemetery</b>		23d. LOCATION (City or Town) <b>Landover</b>	(County) <b>P G Co</b>	(State) <b>Md</b>	
24. FUNERAL DIRECTOR <b>William Spangler ADD 524 8th St N.E.</b>		RECD BY REGISTRAR <b>Charles Jussey</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jussey</b>				
		DATE DEC 5 1967						

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b>		b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>4 hrs 30 min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annandale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>4261 Americana Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Rutledge</b>	Middle <b>Birmingham</b>	Last <b>BARRY</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>8</b>	Year <b>19 67</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13, 1896</b>	9. AGE (In years lost birthday) <b>71 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New York City, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Barry</b>				14. MOTHER'S MAIDEN NAME <b>Evelyn Birmingham</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>081-03-9166</b>		17. INFORMANT <b>Terrace, Fairfax</b> Address <b>Mrs. Helen Stuber, 10117 Spring Lake</b> Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Occlusive coronary arterio-sclerotic disease</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <b>Pulmonary edema</b>					
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>ABQSP</b>	(County) <b>M</b>	(State) <b>Va.</b>	
21. I certify that (s) (this hospital) attended the deceased from <b>8 December 19 67</b> , to <b>8 December 19 67</b> , that (s) (we) last saw the deceased alive on <b>8 December 19 67</b> , and that death occurred <b>ab05P</b> M, fram causes and on the date stated above.							
22a. SIGNATURE <b>Robert E. Gable</b>		M.D. <input type="checkbox"/> ATTENDING PHYS.	MED. <input type="checkbox"/> DIRECTOR	STAFF <input type="checkbox"/> PHYS.	22b. DATE SIGNED <b>9 Dec. 1967</b>		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/11/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Warrenton Cemetery</b>	23d. LOCATION (City or Town) <b>Warrenton</b>		(County) <b>Va.</b>	(State)
24. FUNERAL DIRECTOR <b>Moser Funeral Home</b>		ADDRESS <b>Warrington, Virginia</b>		25a. REC'D BY REGISTRAR <b>J.H. Moser</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	DATE <b>DEC 12 1967</b>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17132		
Item #7 Film #G396 12/21/67 ph CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban					d. STREET ADDRESS 4500 WINDSOR LANE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) TRESSA		First	Middle M	Last BEALL	4. DATE OF DEATH Dec 12 1967		Month	Doy	Year			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/07		9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Murray-Kentucky			12. CITIZEN OF WHAT COUNTRY? 4-SA				
13. FATHER'S NAME John C. Oliver			14. MOTHER'S M AIDEN NAME Edwina (Unknown)									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Husband Homer Beall		Address Same as Item 2.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchopneumonia, bilateral septicemic pneumonia DUE TO 491X										INTERVAL BETWEEN ONSET AND DEATH week		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Meningocele, right fronto-parietal area, residual (Craniotomy 1963)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____, 1967, to Dec. 12, 1967, that (I) (we) last saw the deceased alive on Dec. 11, 1967, and that death occurred at _____ M, from causes and on the date stated above.												
22a. SIGNATURE Philip H. Varner,		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-12-67				
22c. PHYSICIAN'S NAME (Type) PHILIP H. VARNER		22d. ADDRESS 10630 Georgia Ave, Silver Spring, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-14-67		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland						
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY,		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE DEC 15 1967		25b. REGISTRAR'S SIGNATURE Charles J. ...						
VR A15 M 25M 1/62												



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17133

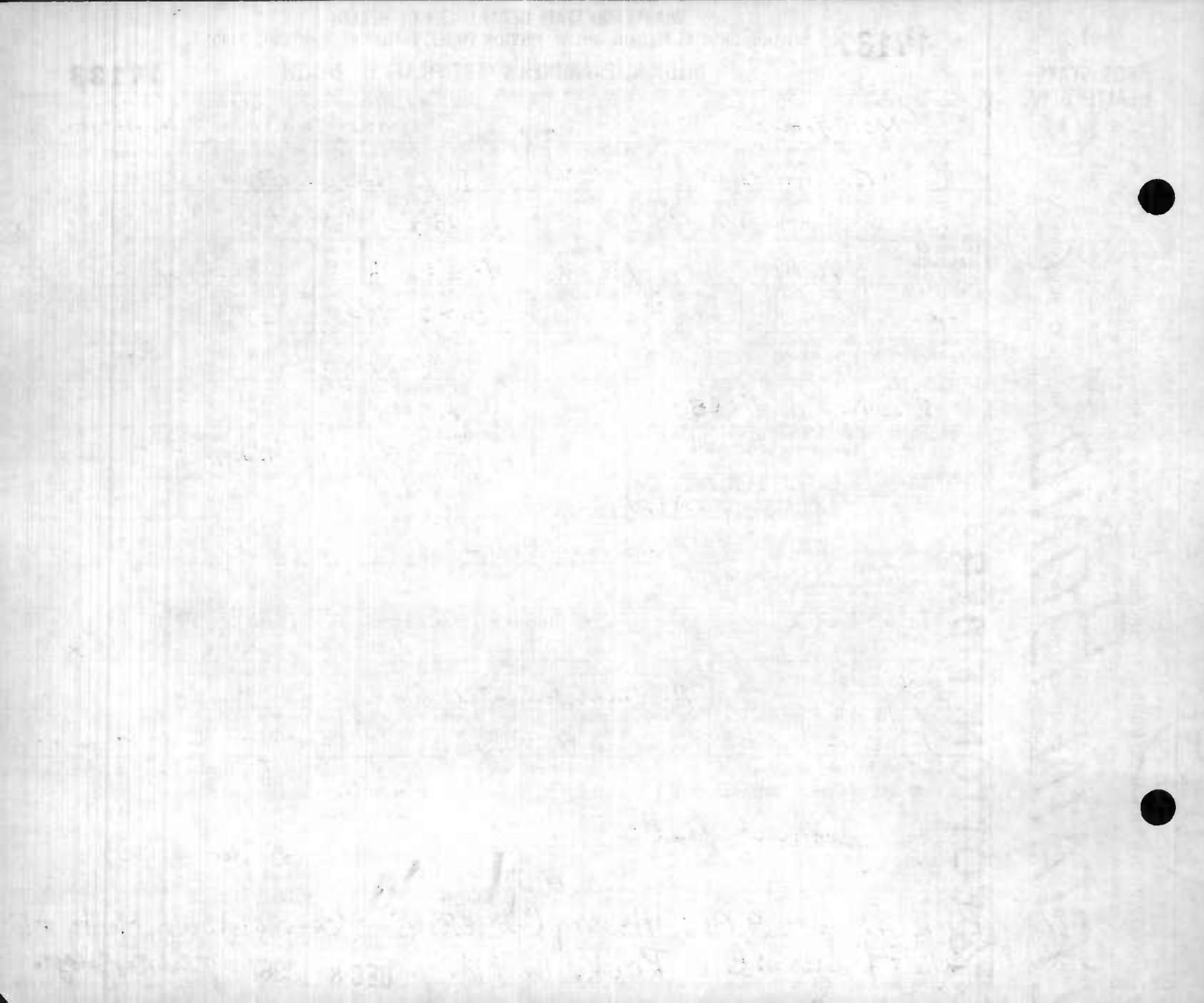
FOR STATE  
HEALTH DEPT.

*M*

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Germantown</b>		c. LENGTH OF STAY IN lb <b>11 Months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 2. Riffleford Rd.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Germantown</b>	
3. NAME OF DECEASED (Type or print) <b>Audry</b>		First <b>Naomi</b>	Middle <b>Beckwith</b>
4. DATE OF DEATH <b>December 4</b>	Month <b>Day</b>	Year <b>1967</b>	
5. SEX <b>Fe.</b>	6. COLOR OR RACE <b>Negrocl</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 24, 1940</b>
9. AGE (In years last birthday) <b>27 yrs.</b>		10. IF UNDER 1 YEAR Months <b>Days</b>	11. IF UNDER 24 HRS. Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>Woodward. Hobbs.</b>		14. MOTHER'S MAIDEN NAME <b>Annie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Father - Box 2. Riffleford Rd Germantown.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>983 X</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Strangulation</b>		DUE TO <b>2 MIN --</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Husband strangled her.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10 am. 12/4 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Trailer.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20f. (City or town) <b>Rural Germantown</b> (County) <b>Montgomery</b> (State) <b>Md.</b>	
ACTUAL SIGNATURE <b>John G. Bell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Dec 4, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIA</b>		23b. DATE THEREOF <b>Dec 9, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Asbury Cemetery</b>
24. FUNERAL DIRECTOR <b>Kobert L. Snodden Rockville, Md.</b>		23d. LOCATION (City or Town) <b>Germantown</b> (County) <b>Montg.</b> (State) <b>Md.</b>	
		25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17134

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>11/26/67 - 12/6/67</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Frank</b>	Middle <b>J.</b>	4. DATE OF DEATH <b>Begley</b> 12 6 1967
5. SEX <b>m</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/7/88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pet. Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pet. Business</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Begley</b>		14. MOTHER'S MAIDEN NAME <b>Callie Begley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>226-16-2139</b>	
17. INFORMANT <b>Earle Matlock-Son-in-law-708 S. Stone-</b>		Street, Ave. Rock	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration</b> Due to <b>Caudiorasculer Collapse / he</b> 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to <b>Aspiration gastric Contents 2 hours</b> (c) Due to <b>Cerebral arterio sclerosis years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1126</b>
20f. (City or town) <b>1126</b> (County) <b>12-6</b> (State) <b>1967</b>			
21. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>11/26/67</b> to <b>12-6-67</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>12-6-67</b> , and that death occurred at <b>6:00</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>M. W. Shapiro</b>		22b. DATE SIGNED <b>12-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. W. Shapiro</b>		22d. ADDRESS <b>8107 Eastern Ave., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/9/67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Maggie Smith Cemetery</b>		23d. LOCATION (City or Town) <b>Jonesville</b> (County) <b>Va.</b> (State)	
24. FUNERAL DIRECTOR <b>Tyson Wheeler F. H.</b>		25a. REC'D BY REGISTRAR <b>1331 Rockville Pike</b> Rockville, Maryland DATE <b>DEC 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

613

WADDELL, ROBERT

613

years old

years old

not tall or short

thin or fat

dark hair or light hair

dark eyes or light eyes

dark skin or light skin

dark hair or light hair

dark eyes or light eyes

dark skin or light skin

dark hair or light hair

dark eyes or light eyes

dark skin or light skin

or black

or brown

or tan

dark hair or light hair

dark eyes or light eyes

dark skin or light skin

or black

or brown

or tan

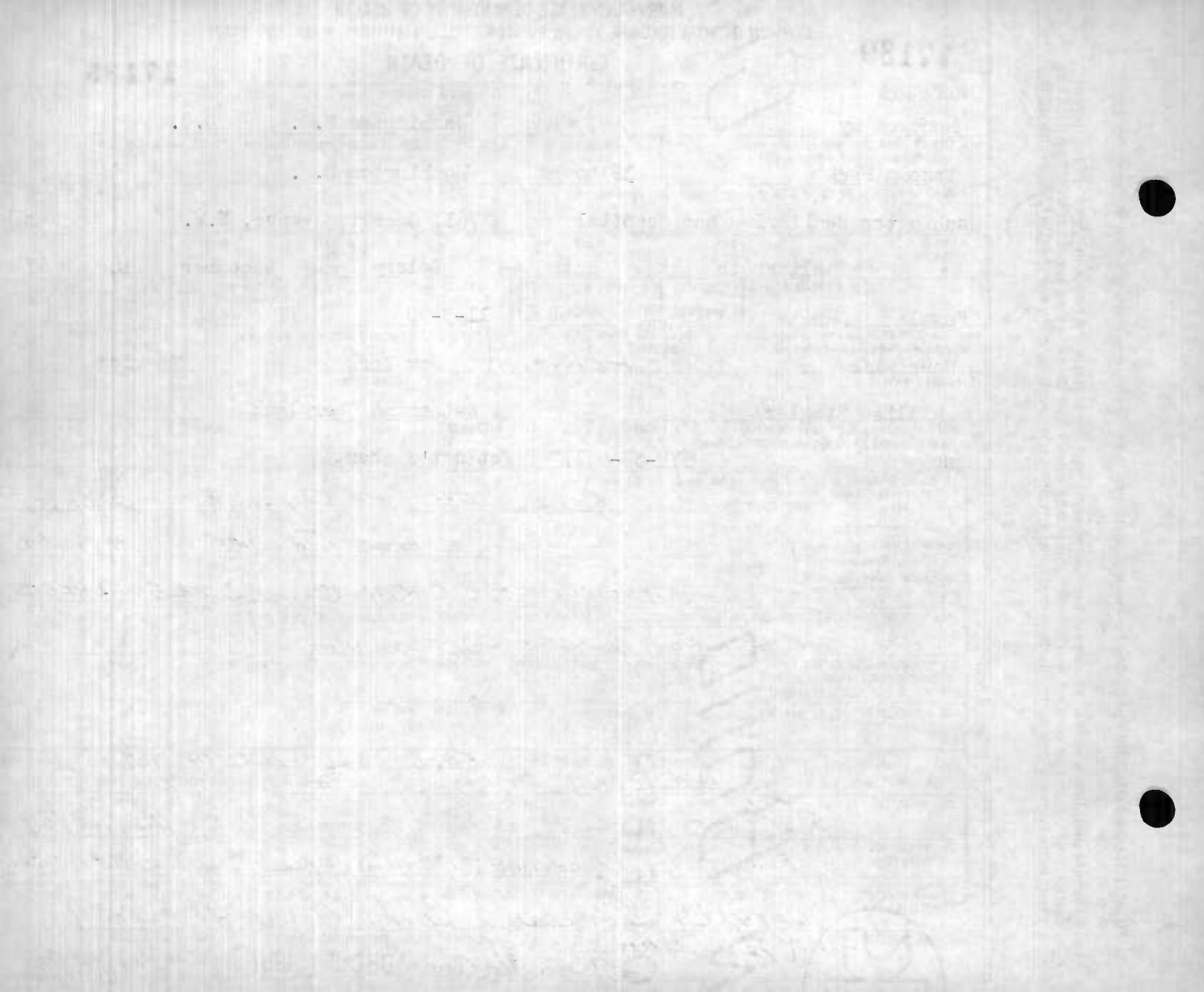
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

17139		17135	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>Washington D.C.</b> b. COUNTY <b>D.C.</b>	
c. LENGTH OF STAY IN 1b <b>36 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		d. STREET ADDRESS <b>7611 Georgia Avenue, N.W.</b>	
<b>3. NAME OF DECEASED</b> First <b>Elizabeth</b> Middle <b>Ruth</b> Last <b>Belsey</b> (Type or print)		<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>14</b> Year <b>1967</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>11-3-90</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>America</b>	
<b>13. FATHER'S NAME</b> <b>William Ziegler</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Katherine Oberglock</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>579-50-6417</b>	
<b>17. INFORMANT</b> <b>Patinet's chart</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>4221</b> <b>Renal Failure - Uremia</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 DAYS</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>Congestive Heart Failure</b> <b>4 months</b> <b>(c)</b> <b>Arteriosclerotic Cardiovascular Disease</b> <b>2 years</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Rheumatoid Arthritis - Deforming</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>New York</b> <b>(County)</b> <b>N.Y.</b> <b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1966</b> , to <b>DEC 14, 1967</b> , that <b>(I) (we)</b> last saw the deceased alive on <b>DEC 13 1967</b> , and that death occurred at <b>2847 M</b> , from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Robert L. Krichmar</b>		<b>22b. DATE SIGNED</b> <b>12/14/67</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Robert L. Krichmar</b>		<b>22d. ADDRESS</b> <b>1733 Alaska Avenue N.W. Washington D.C. 20009</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>12-18-67 Woodlawn Cemetery</b>		<b>23b. DATE THEREOF</b> <b>12-18-67</b>	
<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <b>Woodlawn Cemetery</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>New York N.Y.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Mr. J. Glazerman</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Charles J. Glazerman</b>	
<b>ADDRESS</b> <b>5733 Hal Ave</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles J. Glazerman</b>	
<b>DATE</b> <b>DEC 21 1967</b>			



16  
1 Items 18-21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH  
1-15-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17140 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If 24 hr. delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Howard ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) D.O.A.		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) En Route Montgomery General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hamilton		First Lewis	Middle Bennett
4. DATE OF DEATH 12	Month 24	Doy 1967	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-5-30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mail handler		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	9. AGE (In years last birthday) yrs. 37
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Bennett		14. MOTHER'S MAIDEN NAME Oxna Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO.	17. INFORMANT Florence Bennett, Rte. 32, Simpsonville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to aspiration of blood</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>from ruptured esophageal varices.</u> DUE TO (c)		Address INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Severe fatty infiltration of liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased vomited and aspirated vomitus.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 4:15 pm 12-24 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) (State) Simpsonville Howard Md.		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Belden R. Leap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (State, city, town, or county) <i>Schenectady, NY</i>	
22. DATE SIGNED DEC. 24 1967		23. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 12/29/67		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>		ADDRESS Rockville, Maryland	25a. REC'D BY REGISTRAR JAN 2 1968
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

100% black

medium gray

gray

white

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17137

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM + HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HAROLD JESSE</b>		First <b>BERNEY</b>	Middle <b>BERNEY</b>
4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>19</b> Year <b>1967</b>		5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>6/9/98</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commercial ARTIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PATRICK SIGNS Co</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>If yes give war or dates of service</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Calcific Aortic Stenosis</b> Years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Severe Pulmonary Emphysema</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>(County) (State)</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>10-9-</b> , 19 <b>67</b> , to <b>12-19-</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-19-</b> , 19 <b>67</b> , and that death occurred at <b>3:05PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>S.A. Hillman</b>		22b. DATE SIGNED <b>12/19/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL A. HILLMAN, M.D.</b>		22d. ADDRESS <b>8829 FLOWER AVE SILVER SPRING, MD 20901</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 22, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) <b>Rockville</b> (County) <b>Montgomery</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	
DATE <b>DEC 27 1967</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

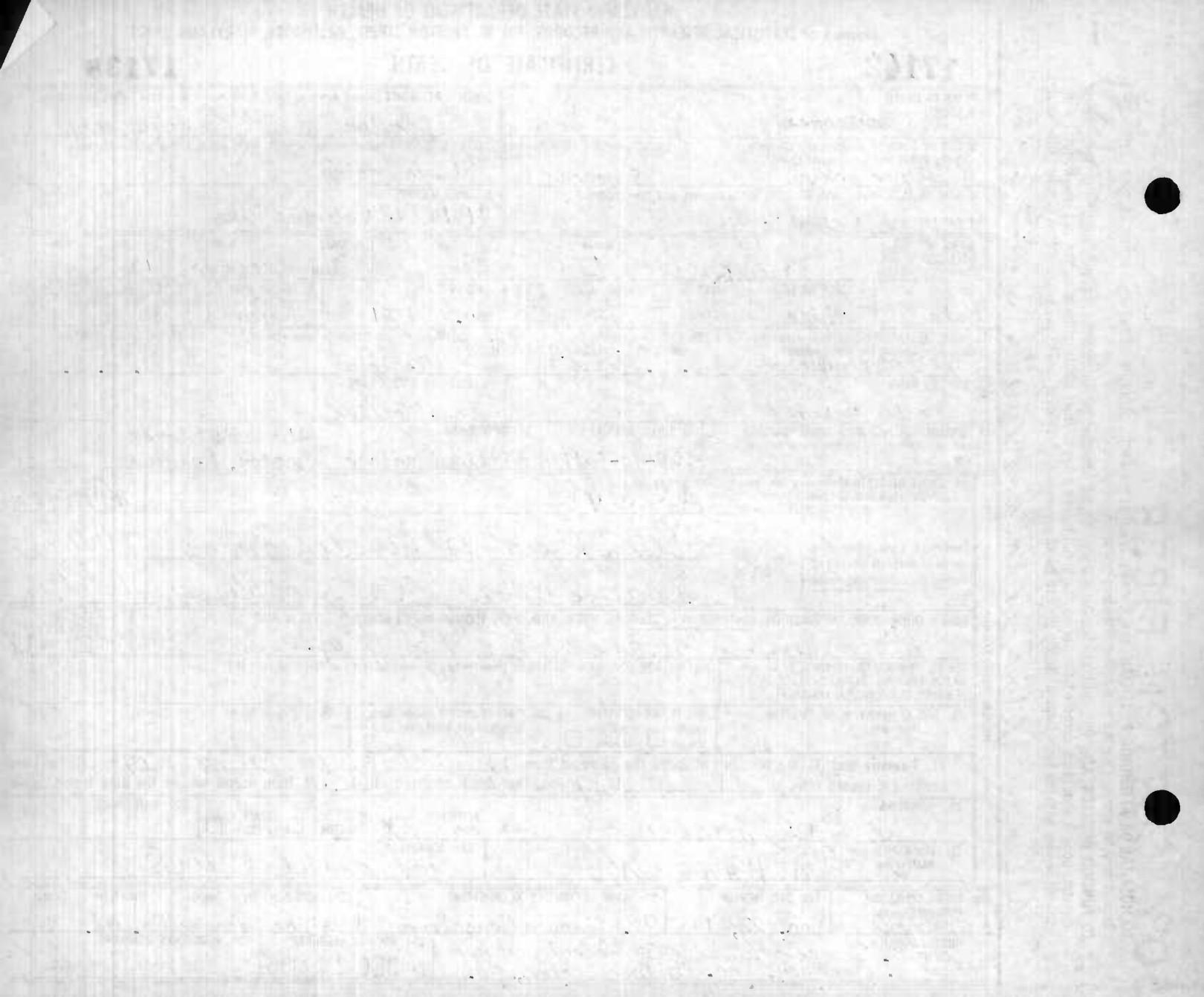
## CERTIFICATE OF DEATH

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**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11919 Old Columbia Pike</b>			d. STREET ADDRESS <b>11919 Old Columbia Pike</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>First</b> <b>Henry</b> <b>Middle</b> <b>L</b> <b>Last</b> <b>Berry</b>		4. DATE OF DEATH <b>Month</b> <b>December</b> <b>Day</b> <b>19</b> <b>Year</b> <b>1967</b>			
5. SEX <b>Male</b> 6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 1891</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D. C. Transit</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Wesley Berry</b>			14. MOTHER'S MAIDEN NAME <b>Dora Rollins</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-46-5611</b>		17. INFORMANT <b>William Marlowe</b> <b>Address</b> <b>4416 Ives Street</b> <b>Wheaton, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A.S.CVD-</b>			INTERVAL BETWEEN DEATH AND DEATH <b>8 mos.</b>		
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			10 yrs.		
DUE TO (c)			15 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Bronchitis + Emphysema</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>11/10</b> , 19 <b>67</b> , to <b>12/14</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>11/10</b> , 19 <b>67</b> , and that death occurred at <b>6:00 PM</b> , from causes and on the date stated above.		20f. (City or town) <b>Laurel</b> (County) <b>Md.</b> (State)			
22a. SIGNATURE <b>J M Warren</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Laurel Md</b>	
22c. PHYSICIAN'S NAME (Type) <b>J M Warren</b>		22d. ADDRESS <b>Prince Georges Co. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE THEREOF <b>Dec. 23, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Mausoleum</b>	
24. FUNERAL DIRECTOR <b>John E. Warner</b>		ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

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**CERTIFICATE OF DEATH**

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17140

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sahurian</i>		d. STREET ADDRESS <i>4216 Leland St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Marcella</i>	Middle <i>P.</i>	Last <i>Blanchard</i>
4. DATE OF DEATH Month <i>December</i> Doy <i>10</i> Year <i>1967</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-14-06</i>
9. AGE (In years last birthday) <i>62 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Nebraska</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Bruce Palmer</i>	14. MOTHER'S MAIDEN NAME <i>Madeline Hardig</i>	Address <i>Mr Wendell Blanchard - absent</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT <i>Mr Wendell Blanchard - absent</i>	18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Carcinomatosis</i>
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. <i>170X</i>		DUE TO (b) <i>Adenocarcinoma, breast</i>	INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> or work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Blanchard</i> (County) <i>Montgomery</i> (State) <i>MD</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1967</i> , to <i>Dec 10 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 10 1967</i> , and that death occurred at <i>83p</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>William H. Kille</i>		22b. DATE SIGNED <i>10-11-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. William H. Kille</i>		22d. ADDRESS <i>8218 Wisc. Ave. Bethesda, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>12/12/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL CREM.</i>
23d. LOCATION (City or Town) <i>SUITLAND, MD.</i> (County) <i>MARYLAND</i> (State) <i>MD</i>			
24. FUNERAL DIRECTOR <i>Joseph Laufer Son Washington DC</i>		25a. ADDRESS <i>1100 Connecticut Ave. N.W. Washington, D.C.</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>
		25c. REC'D BY REGISTRAR <i>REC'D DEC 15 1967</i>	25d. DATE <i>DEC 15 1967</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17908

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

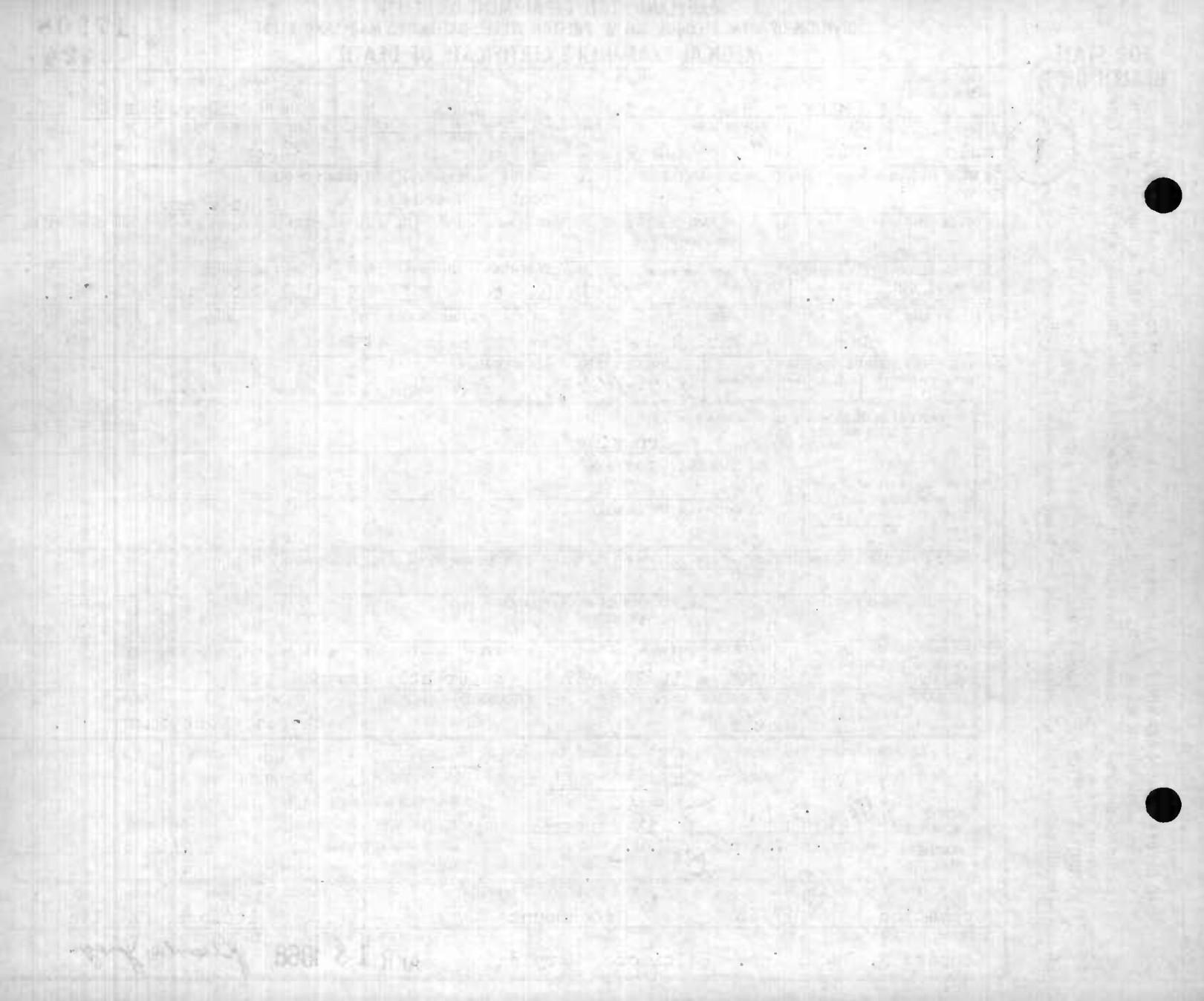
FOR STATE  
HEALTH DEPT.

Any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page  
5 may be retained for your files.

2

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN <input type="checkbox"/> Month Day Year DEATH ESTI. MATED <input checked="" type="checkbox"/> December 18 1967	2b. HOUR UNK M
MARK		A	BLUME			
3. SEX male	4. RACE white	S. DATE OF BIRTH July 11, 1944	6. AGE (in years last birthday) 23 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month April Day 13, Year 1968	2d. HOUR UNKM
7a. BIRTHPLACE (State or foreign country) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, D.C.		13b. COUNTY	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4101 Cathedral Ave. N.W.	
14. FATHER'S NAME Jack		Middle Paul Blume	Last	15. MOTHER'S MAIDEN NAME Ethel	Middle	Lost Nelson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-44-9773		17. INFORMANT	ADDRESS WASH. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 929.8						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. UNK P.M. 12/18 19 67	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) apparently drowned			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) water	21f. LOCATION Street or R.F.D. No.		City or Town Bethesda, Montgomery, Md.	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE 	EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED 4/17/68	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 4/17/68	23c. NAME OF CEMETERY OR CREMATORIAL Greenmount		23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)
24. FUNERAL DIRECTOR	ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland		25a. REC'D BY REGISTRAR APR 18 1968	25b. REGISTRAR'S SIGNATURE 		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

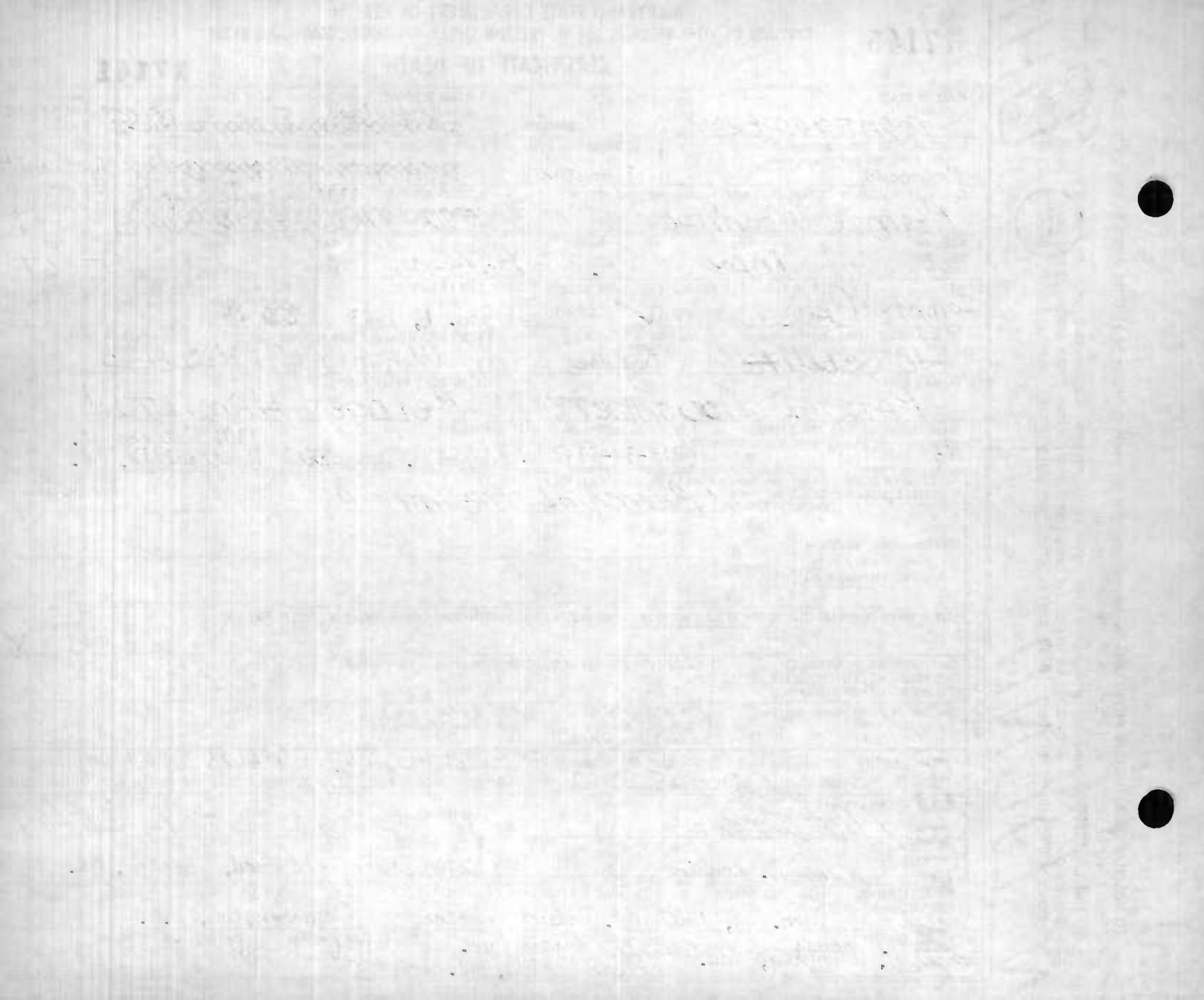
Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17145

CERTIFICATE OF DEATH

17141

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>3 months</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Resmar Hospital</i>		d. STREET ADDRESS <i>3301 Rutgers Street</i>	
3. NAME OF DECEASED (Type or print) <i>FEMALE</i>		first <i>MAY</i>	Middle <i>A.</i>
4. DATE OF DEATH <i>Jan. 1, 1883</i>		Last <i>Boiseau</i>	Month <i>12</i>
5. SEX <i>Cauc.</i>		6. COLOR OR RACE <i>WIDOWED</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED
8. DATE OF BIRTH <i>Jan. 1, 1883</i>		9. AGE (In years last birthday) <i>83 84</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington DC USA</i>		12. CITIZEN OF WHAT COUNTRY <i>Address: 3301 Rutgers St. Hyattsville, Md.</i>	
13. FATHER'S NAME <i>PATRICK Dougherty</i>		14. MOTHER'S MAIDEN NAME <i>BRIDGET HAMILTON</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-34-5337</i>	
17. INFORMANT <i>D. Edward J. Dougherty</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>491X</i> IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ stating the underlying cause (c) _____	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) <i>Hyattsville</i> (County) <i>Maryland</i> (State) <i>Md.</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 19, 1967</i> to <i>Dec 25, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 25, 1967</i> , and that death occurred at <i>9039 M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>M. Lenkin</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22b. DATE SIGNED <i>12-25-67</i>		22d. ADDRESS <i>2309 Shorefield Rodd, Wheaton, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 28, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Olivet Cemetery</i>
23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>		23e. REGISTRAR'S SIGNATURE <i>Judie Juge</i>	
24. FUNERAL DIRECTOR <i>Thomas Shatzberg</i>		25a. REC'D BY REGISTRAR <i>DEC 28 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Judie Juge</i>
24b. ADDRESS <i>Georgia Ave. Silver Spring, Md.</i>		25c. DATE	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

PAGE 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2226 Washington Avenue</b>						d. STREET ADDRESS <b>2226 Washington Ave.</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>ROSE</b>		First	Middle	Last	4. DATE OF DEATH <b>12-26-67</b>	Month	Day	Year			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-3-95</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Gershon Gottlieb</b>						14. MOTHER'S MAIDEN NAME <b>Sarah</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address <b>Bethesda, Md.</b> <b>Louis Bojan(SON) 7005 Loch Lomond Dr.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4200</i> <i>Neuromuscular degeneration</i> DUE TO <i>Arterosclerosis arteriostenosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) <i>Heart disease</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Hyattsville</i> (County) <i>Md.</i> (State) <i>Maryland</i>					
21. I certify that (I) (this hospital) attended the deceased from <i>11/6/67</i> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>12/4/67</i> , 19____, and that death occurred at <i>3:30 AM</i> , fram causes and an the date stated above.											
22a. SIGNATURE <i>Bernard J. Walsh</i>											
22c. PHYSICIAN'S NAME (Type) <b>BERNARD J. WALSH</b>		22d. ADDRESS <i>1800 Eye St. N.W.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-28-67</b>		23c. NAME OF CEMETERY OR CREMATORIALy <b>Mt. Lebanon Cemetery</b>		23d. LOCATION (City or Town) <i>Hyattsville</i> (County) <i>Md.</i> (State) <i>Maryland</i>					
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>		ADDRESS <b>3501 14th St. N.W. Washington, DC 20010</b>		25a. REC'D. BY REGISTRAR DATE <b>DEC 29 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

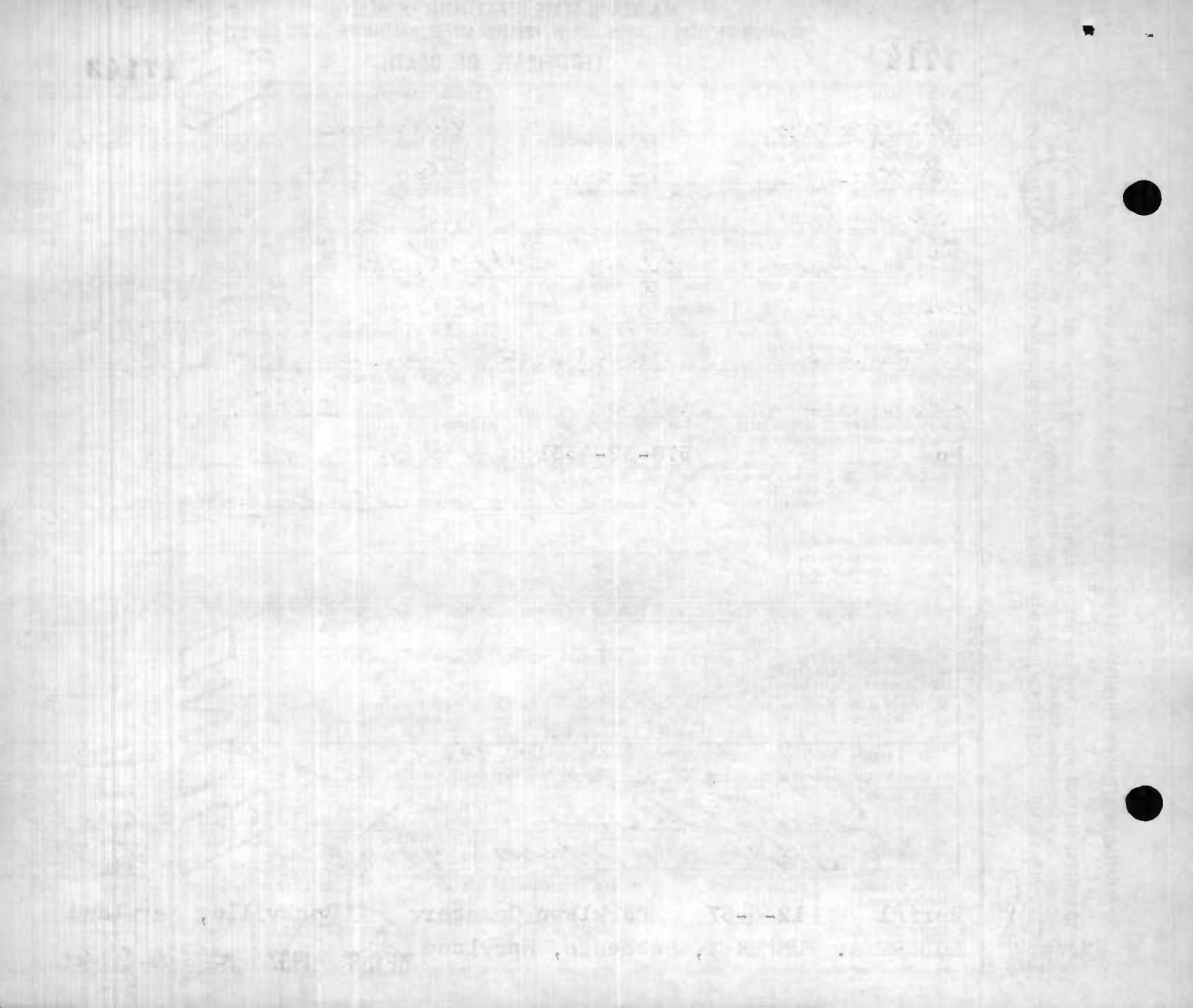
CERTIFICATE OF DEATH

17143

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. <sup>Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.</sup>

17147		CERTIFICATE OF DEATH										17143	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>2 DAYS.</u>					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN ECHO</u>					<b>4. DATE OF DEATH</b> <u>Dec. 4 1967</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>LAWRENCE OLIVER BOLTON, SR.</u>					<b>4. DATE OF DEATH</b> <u>Dec. 4 1967</u>					<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2/6/1894</u>			<b>9. AGE (In years last birthday)</b> <u>73 yrs.</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		<b>11. IF UNDER 24 HRS.</b> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt. CTS OFFICE</u>			<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>MARYLAND, Gaithersburg U.S.A</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>				
<b>13. FATHER'S NAME</b> <u>Lewis Edward Bolton</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>ODEN, Ida L.</u>					<b>17. INFORMANT</b> <u>RUTH BOLTON - WIFE - SAME</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Bronchogenic carcinoma</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) _____ DUE TO _____ (c) _____											INTERVAL BETWEEN ONSET AND DEATH <u>3 years.</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. _____			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>5001 Bethesda Lane</u>			<b>20f. (City or town)</b> <u>Rockville</u> <b>(County)</b> <u>Maryland</u> <b>(State)</b> <u>MD</u>				
<b>21. I certify that (I) (this hospital) attended the deceased from <u>1964</u>, to <u>1967</u>, that (I) (we) last saw the deceased alive on <u>3 Dec 1967</u>, and that death occurred at <u>5001 Bethesda Lane</u>, fram causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>John J. Darrow</u>					<b>22b. DATE SIGNED</b> <u>4 Dec 67</u>								
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>John J. Darrow</u>					<b>22d. ADDRESS</b> <u>4917 Bethesda Lane Bethesda</u>								
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>12-6-67</u>			<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <u>Parklawn Cemetery</u>			<b>23d. LOCATION (City or Town)</b> <u>Rockville</u> <b>(County)</b> <u>Maryland</u> <b>(State)</b> <u>MD</u>				
<b>24. FUNERAL DIRECTOR</b> <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>					<b>25a. REC'D BY REGISTRAR</b> <u>DEC 8 1967</u>					<b>25b. REGISTRAR'S SIGNATURE</b> <u>J Charles Judge</u>			



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17148

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

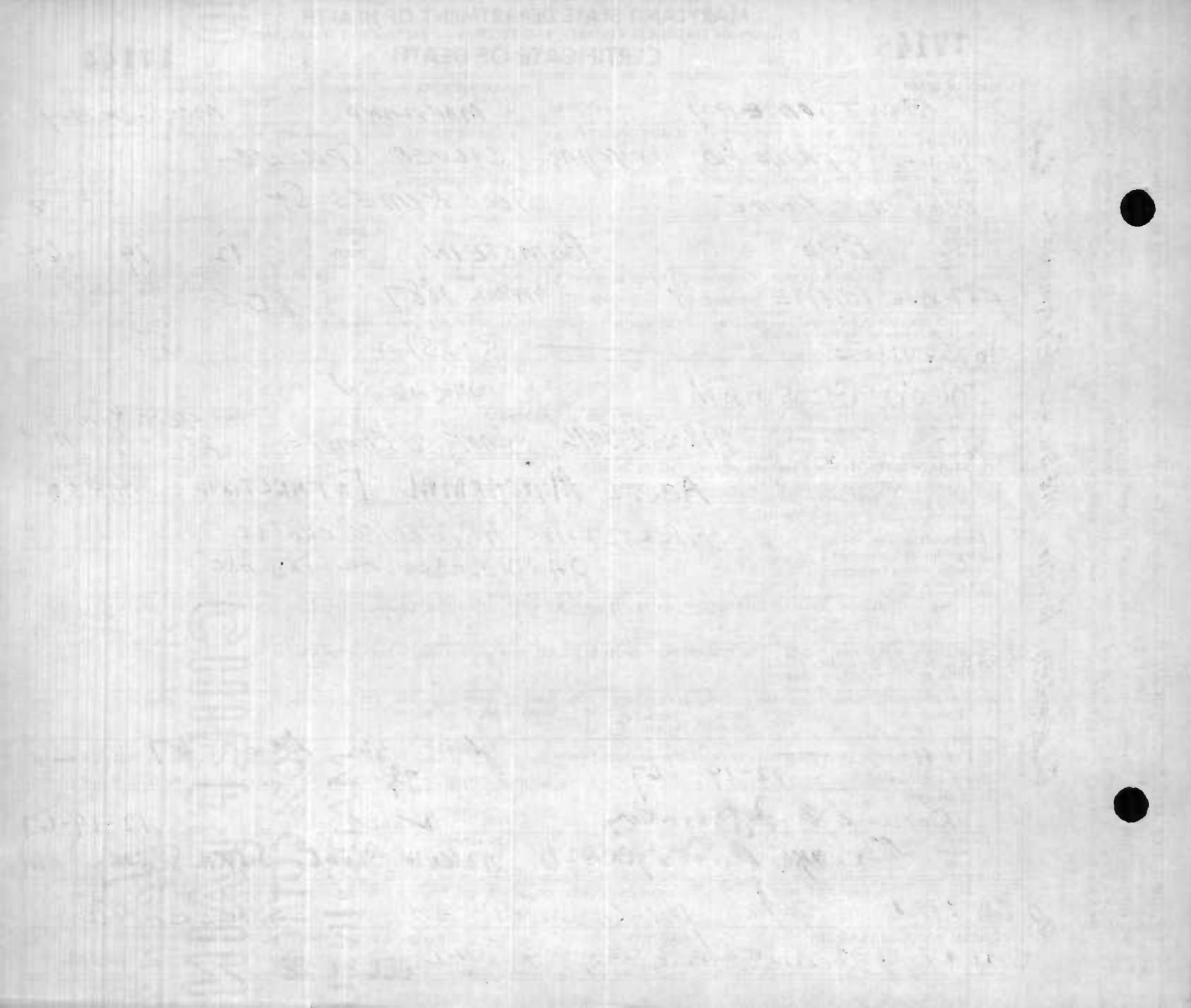
17144

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**CLEARED WITH MEDICAL EXAMINER'S OFFICE**

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND		b. COUNTY		MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING		d. STREET ADDRESS		15-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		DIED AT HOME		d. STREET ADDRESS		9000 KIMES ST		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	8. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.			
FEMALE		WHITE		APPROX 1887	80 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
HOUSEWIFE				RUSSIA		U.S.					
13. FATHER'S NAME		JACOB GROSMAN		14. MOTHER'S MAIDEN NAME		UNKNOWN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		9000 KIMES			
NO		218-52-9096		SANFORD BOMSTEIN		81, SIC Spc. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ACUTE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH		IMMEDIATE			
		4201		HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	DUE TO								
		(c)	DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
Hour	a. m.		p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from _____		Jan 52		to _____		Dec 1967		, 1967		that (I) (we) last saw the deceased alive on 12-19 1967, and that death occurred at 73 M, from the causes and on the date stated above.	
22a. SIGNATURE		BERNARD A. FITZGERALD		M.D.	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		BERNARD A. FITZGERALD		22d. ADDRESS		217 UNIV BLVD, SILVER SPRING MD				12-19-67	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county)		(State)			
BURIAL		12/22/67		MT. Lebanon Cem.		HYATTSVILLE, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Deedey Funeral Home		4217-9 E ST NW		DATE DEC 26 1967		Charles Judge					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

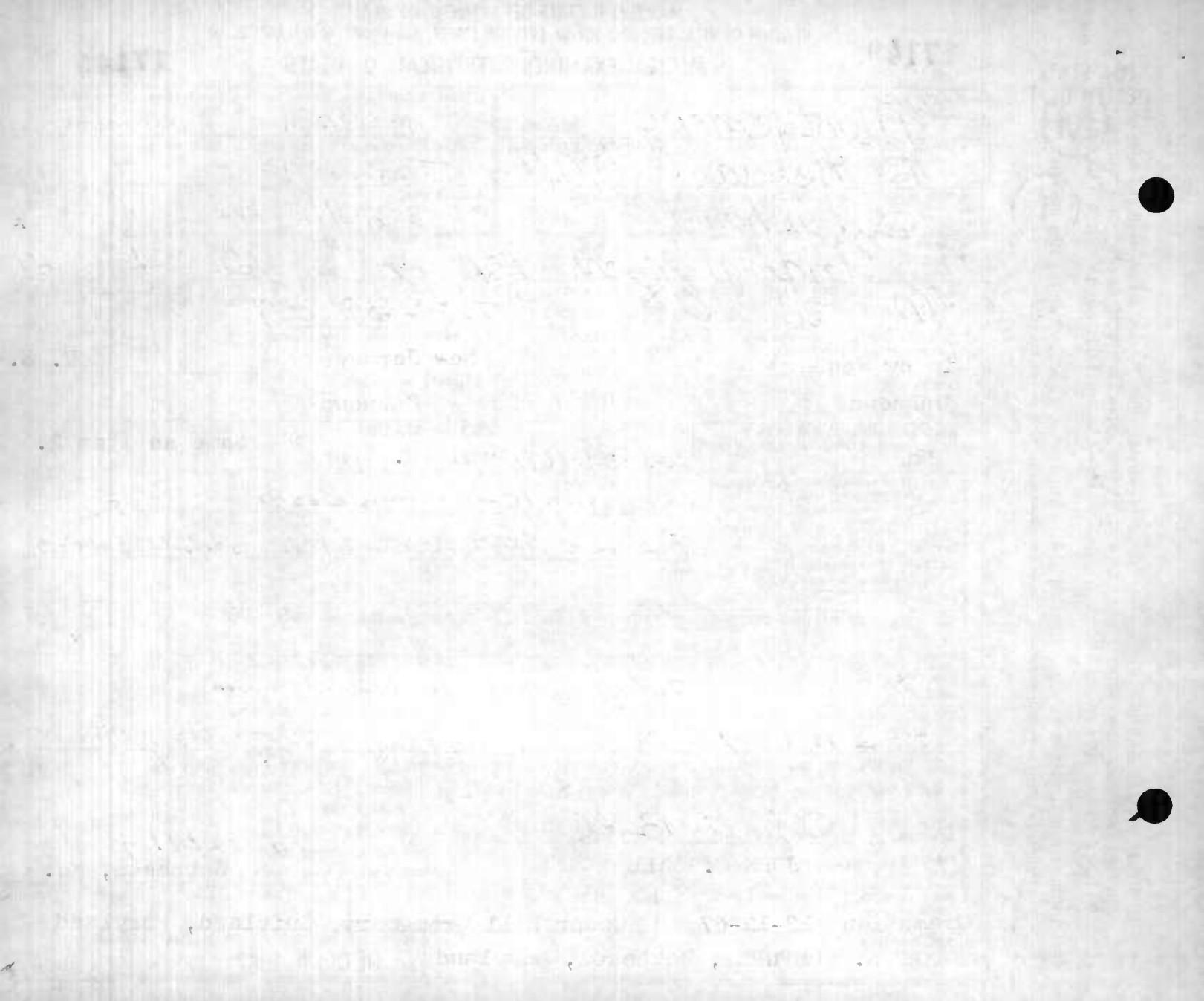
17149

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17145

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Montgomery</i> <i>Maryland</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda &amp; D.O.A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. LENGTH OF STAY IN 1b. <i>Suburban</i>		e. STREET ADDRESS <i>506 Tulip Ave.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Andrew Joseph Bragg</i>		First	Middle
4. DATE OF DEATH 12 - 4 1967		Month	Day
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WOOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>7-30-30</i>
9. AGE (In years lost/birthday) <i>37 yrs.</i>		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Window Washer</i>		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>228-32-6674</i>	17. INFORMANT wife <i>Mamie M. Bragg</i>
		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>902.6</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Scat</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Fall from scaffolding</i>		DUE TO <i>Fracture of skull - due to fall from scaffolding</i>	
(c)		DUE TO <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fall off scaffolding when closing windows</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>8:45 pm 12-4 1967</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>office bldg.</i>
		20f. (City or town) (County) (State) <i>Bethesda Mont. Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i>Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>12-12-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>
23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>		23e. ADDRESS	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. RECD BY REGISTRAR <i>DEC 18 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17150 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17148

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN lb 1qr. 9mos. 23days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORFOLK
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHESDA - SILVER SPRING NURSING HOME		d. STREET ADDRESS 6913 LALLISTER RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	Fist KOLAND	Middle Mo Brainard	4. DATE OF DEATH Month 12 Doy 28 Year 1967
S. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-17-86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VICE ADMIRAL - USNAY - RET.		9. AGE (In years last birthday) 81 yrs.	
11. BIRTHPLACE (County & State, or foreign country) ANNAPOLIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDERICK BRAINARD		14. MOTHER'S MAIDEN NAME MARY ANN MUNROE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 264 52 9192 17. INFORMANT PATIENT'S CHART # 1 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO <i>Cerebral arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Ganglionic angiokeratosis</i> yrs. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 26</i> , 1966, to <i>12/28</i> , 1967, that (I) ( ) last saw the deceased alive on <i>12/28</i> 1967, and that death occurred at <i>2:15 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>G. Lennard Gow</i>			
22c. PHYSICIAN'S NAME (Type) <i>G. Lennard Gow</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/23/67</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-2-1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS U.S.N.ACADEMY
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis Md.		25a. REC'D. BY REGISTRAR JAN 3 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. George</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington</i> b. COUNTY <i>D.C.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. LENGTH OF STAY IN 1b <i>3 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Randolph Hills Nursing Home</i>			d. STREET ADDRESS <i>2916 7th St N.E.</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>GERTRUDE</i>		First	Middle	Last	4. DATE OF DEATH Dec 29 1967 Month Day Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>3-18-1892</i>	9. AGE (In years lost birthday) <i>75 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Social Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Amer. Red Cross</i>		11. BIRTHPLACE (County & State, or foreign country) <i>District of Col.</i>	
13. FATHER'S NAME <i>Richard Brauner</i>			14. MOTHER'S MAIDEN NAME <i>Caroline Hanke</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-44-5279A</i>		17. INFORMANT <i>Evelyn Woodward - Neice</i> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>5810</i> IMMEDIATE CAUSE (a) <i>Cirrhosis of the liver</i>			INTERVAL BETWEEN ONSET AND DEATH <i>under</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO _____ lost. _____ DUE TO _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>10820 Georgia Ave, S. Supts, Md.</i> (County) <i>942-5022</i> (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>10-9, 1967</i> , to <i>12/29, 1967</i> , that (I) (we) last saw the deceased alive on <i>12-19 1967</i> and that death occurred at <i>6 A.M.</i> from causes and on the date stated above.					
22a. SIGNATURE <i>B.C. Bendlar MD</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>B. C. Bendlar MD</i>		22d. ADDRESS <i>10820 Georgia Ave, S. Supts, Md.</i>		22b. DATE SIGNED <i>12/29/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>12/31/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Lee Crematory</i>	
24. FUNERAL DIRECTOR <i>Lee F.H., 300 4th St NE, Wash., D.C.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>JAN 2 1968</i> DATE	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be reigned by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17152		17148	
1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
MONTGOMERY MARYLAND		WASH. D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN 16 37 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WHEATON NURSING HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH. D.C. 47-3	
3. NAME OF DECEASED (Type or print)		First MARY	Middle C. BREEN
4. DATE OF DEATH		Month 12	Doy 21
5. SEX F.		6. COLOR OR RACE White	7. MARRIED NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH OCT. 8-1872		9. AGE (In years lost birthday) 95 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-TEACHER		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.
13. FATHER'S NAME MICHAEL BREEN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-30-5280-A	17. INFORMANT Address Robert J. Beller-3024 Oliver St. NW. Wash. D.C.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 3 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease, Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 1964 to Dec. 21, 1967, that (I) (we) last saw the deceased alive on Dec. 21 1967, and that death occurred at 9:30 P.M. from causes and on the date stated above.		22b. DATE SIGNED	
22c. SIGNATURE Bertram F. Schaefer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 1780 Mass Ave. N.W. Wash. D.C.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-1967	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Inc.		ADDRESS 5130 Wisc. Ave. N.W. Wash. D.C.	25a. REC'D BY REGISTRAR DAT DEC 28 1967
			25b. REGISTRAR'S SIGNATURE Charles J. Judge

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STANFORD LIBRARIES

9212



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>			d. STREET ADDRESS <i>10300 West Lake Dr.</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Edward</i>		First	Middle	Last <i>Brennan</i>	4. DATE OF DEATH Month <i>Dec</i> Day <i>24</i> Year <i>1967</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>9-25-1897</i> 9. AGE (In years last birthday) <i>70 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>MADISON, Wisc.</i>	
13. FATHER'S NAME <i>Thomas Brennan</i>		14. MOTHER'S MAIDEN NAME <i>KATHRYN</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT (WIFE) <i>GERTRUDE BRENNAN Same as #2</i>	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>					
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerotic Heart Disease</i> 5 yrs					
stating the underlying cause (c) <i>Generalized arteriosclerosis</i> 20 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10-7</i> , 19 <i>66</i> , to <i>12-24</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>12-24</i> 19 <i>67</i> , and that death occurred at <i>985 M</i> , fram causes and an the date stated above.					
22a. SIGNATURE <i>Ronald W. Barr</i>		22b. DATE SIGNED <i>12-24-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Ronald W. Barr</i>		22d. ADDRESS <i>10401 Old Georgetown Rd. Bethesda, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-28-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cem.</i>	
23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>James E. D. S. &amp; Sons Funeral Home - Wash. D.C.</i>		ADDRESS		DATE JAN 2 1968	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

101-HB-2

note

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 2 and 3, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland St. Marys ✓ b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS MEMQ 777A	
3. NAME OF DECEASED (Type or print) Christine Marie BREWER		f. DATE OF DEATH December 9 1967	
4. SEX Female Cauc		g. COLOR OR RACE WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
5. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		6. 10b. KIND OF BUSINESS OR INDUSTRY N/A	
7. 11. BIRTHPLACE (County & State, or foreign country) Patuxent River, Md.		8. DATE OF BIRTH Dec. 8, 1967	
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Dys Hours Hours Min.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wiley Phillip Brewer	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A	
16. SOCIAL SECURITY NO. N/A		17. INFORMANT Mr. Wiley P. Brewer, MEMQ 777A Patuxent/	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningomyelocele 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While Not While of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from Dec. 8, 1967, to Dec. 9, 1967, that (t) (we) last saw the deceased alive on Dec. 9, 1967, and that death occurred at 1245 M, fram causes and an the date stated above.			
22a. SIGNATURE Jerry J. Tomasovic		22b. DATE SIGNED Dec. 12, 1967	
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-14-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR DATE DEC 15 1967	
		25b. REGISTRAR'S SIGNATURE M. L. D. 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

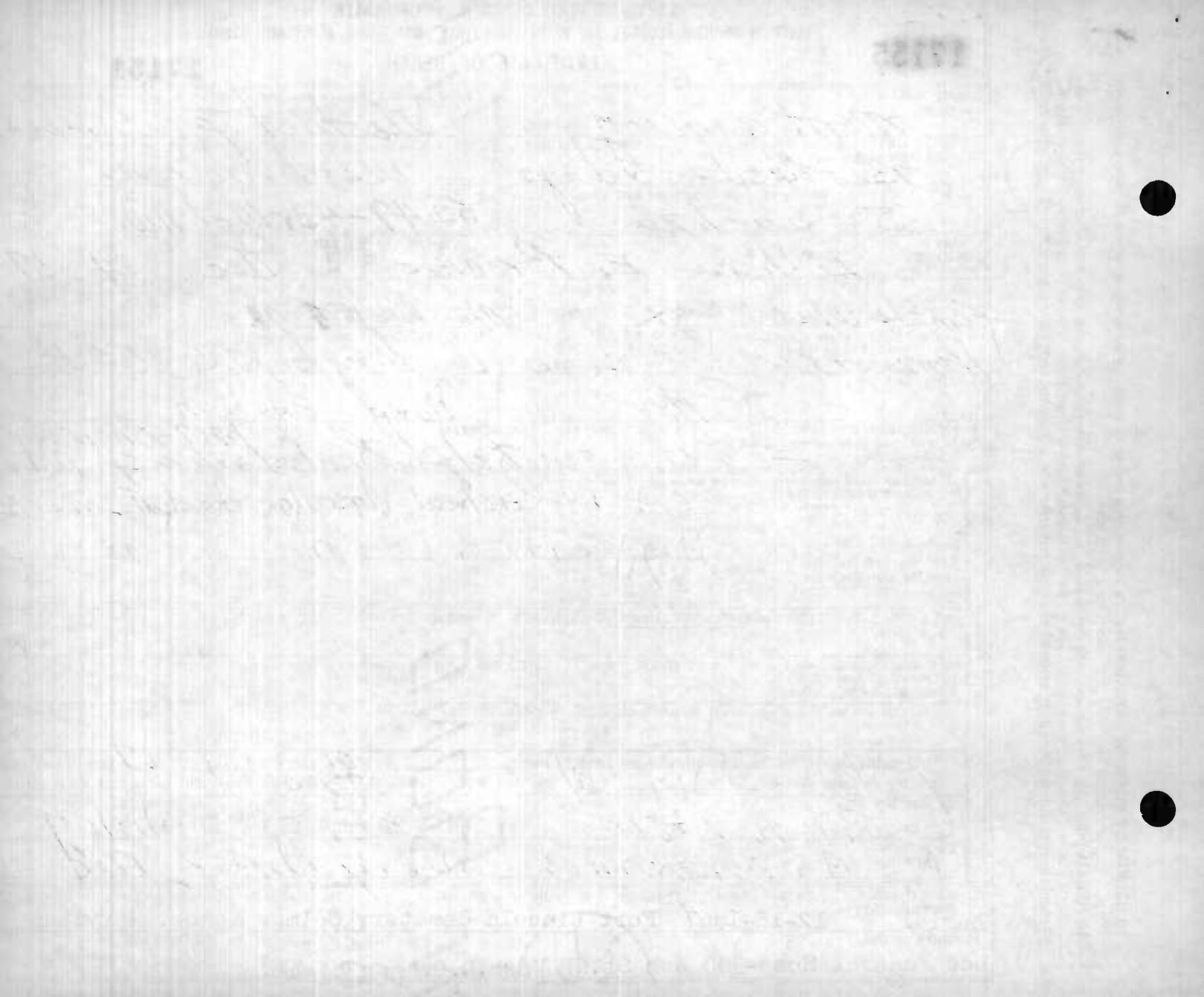
17155

CERTIFICATE OF DEATH

17151

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Montgomery Maryland</i>		<i>District of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda 3 days</i>		c. LENGTH OF STAY IN 1b <i>Suburbia</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburbia</i>		d. STREET ADDRESS <i>5249-43rd St. N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Lillian</i>	Middle <i>E. Broches</i>
4. DATE OF DEATH Month <i>Tec.</i>		Day <i>14</i>	Year <i>1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>March 16 1895</i>	9. AGE (In years lost birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home or no</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>
13. FATHER'S NAME <i>Ritter</i>	14. MOTHER'S MAIDEN NAME <i>Dora English</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>579-18-5921</i>		17. INFORMANT <i>Ralph Brooks Silver Spring Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertension</i>		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days - Bright day</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Oberry Chase Md.</i>
20f. (City or town) <i>Oberry Chase Md.</i>		(County) <i>Montgomery Co.</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>12/14/67</i> to <i>12/14/67</i> , 1967, that (I) (we) last saw the deceased alive on <i>12/14/67</i> , 1967, and that death occurred at <i>9:30 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>12/17/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. S. Brennan</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-18-1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>
24. FUNERAL DIRECTOR <i>Lee Funeral Home-300 4th St. NE Wash. D.C.</i>		ADDRESS <i>Colmar Manor. Maryland</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>
		DATE <i>DEC 21 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



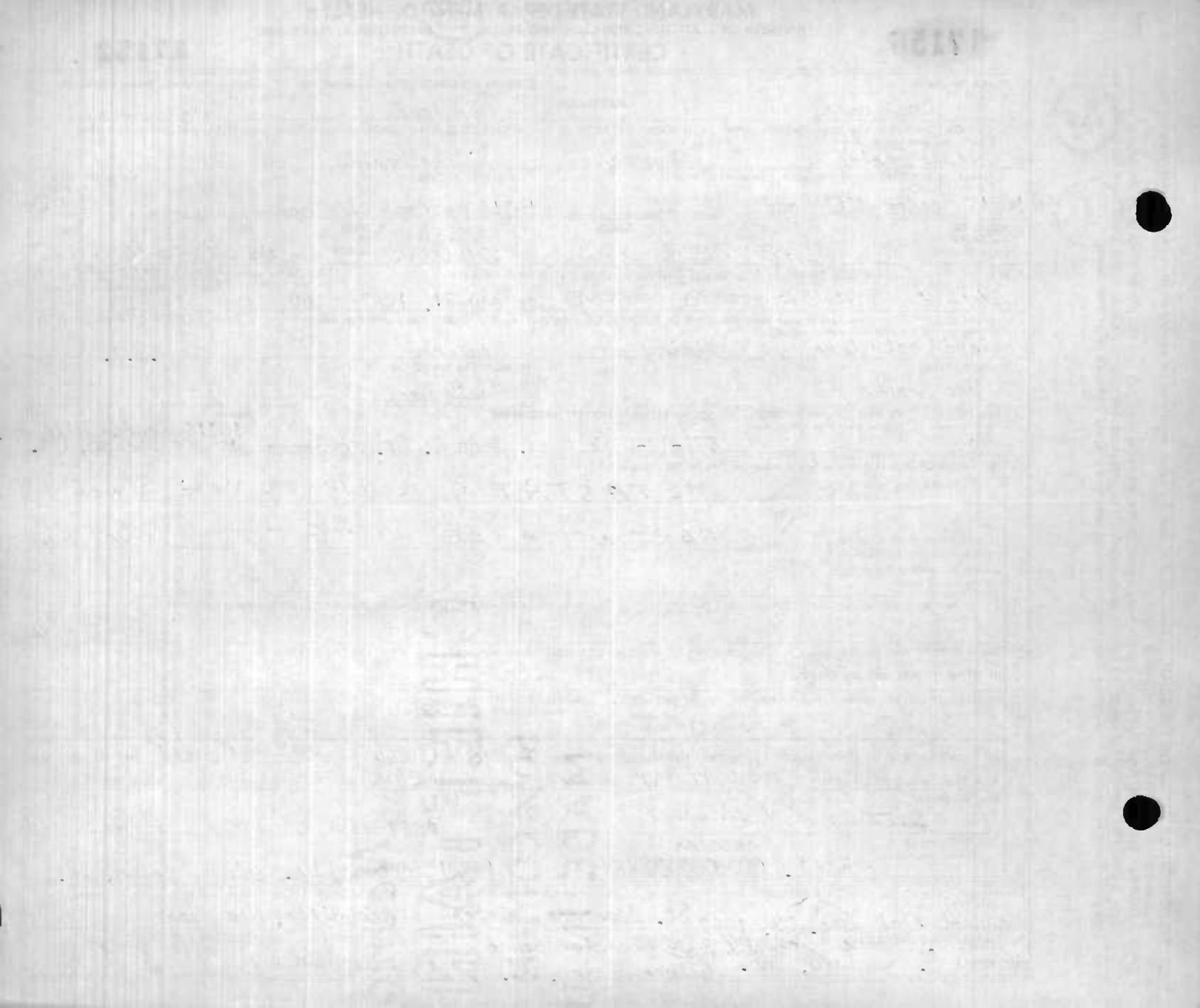
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**TO FUNERAL DIR.:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

17156                          17152

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>3 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>10715 Meadow Hill Road</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10715 Meadow Hill Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>CHESTER John</i>		First	Middle	Last	4. DATE OF DEATH <i>BROOKS</i>	Month	Day	Year
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <i>January 31, 1907</i>	9. AGE (In years lost birthday) yrs. <i>60</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Coal Miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mining</i>		11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Ira Brooks</i>		14. MOTHER'S MAIDEN NAME <i>Annie Deel</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-38-0382</i>		17. INFORMANT <i>Mrs. Leda R. St. Lawrence</i>		Address <i>10715 Meadow Hill Rd. Silver Spring, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163x</i>		DUE TO <i>CARCINOMA OF LUNG</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 MONTHS</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <i>CARCINOMA OF LUNG</i>		UNKNOWN				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>MARCH 24, 1966</i> to <i>DEC 18, 1967</i> , that (I) (we) last saw the deceased alive on <i>DEC 17, 1967</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.								
22a. SIGNATURE <i>Arthur S. Bressler</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>DEC-18-1967</i>		
22c. PHYSICIAN'S NAME (Type) <i>Arthur S. Bressler</i>		22d. ADDRESS <i>10881 Lockwood Dr., Silver Spring, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Trans-burial</i>		23b. DATE THEREOF <i>Dec. 22, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Lawrence Cemetery</i>		23d. LOCATION (City, town, or county) <i>Sayville, New York</i>		(State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>John B. Warner E. Phumphrey, Inc.</i>		ADDRESS <i>10715 Meadow Hill Rd. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 27 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		

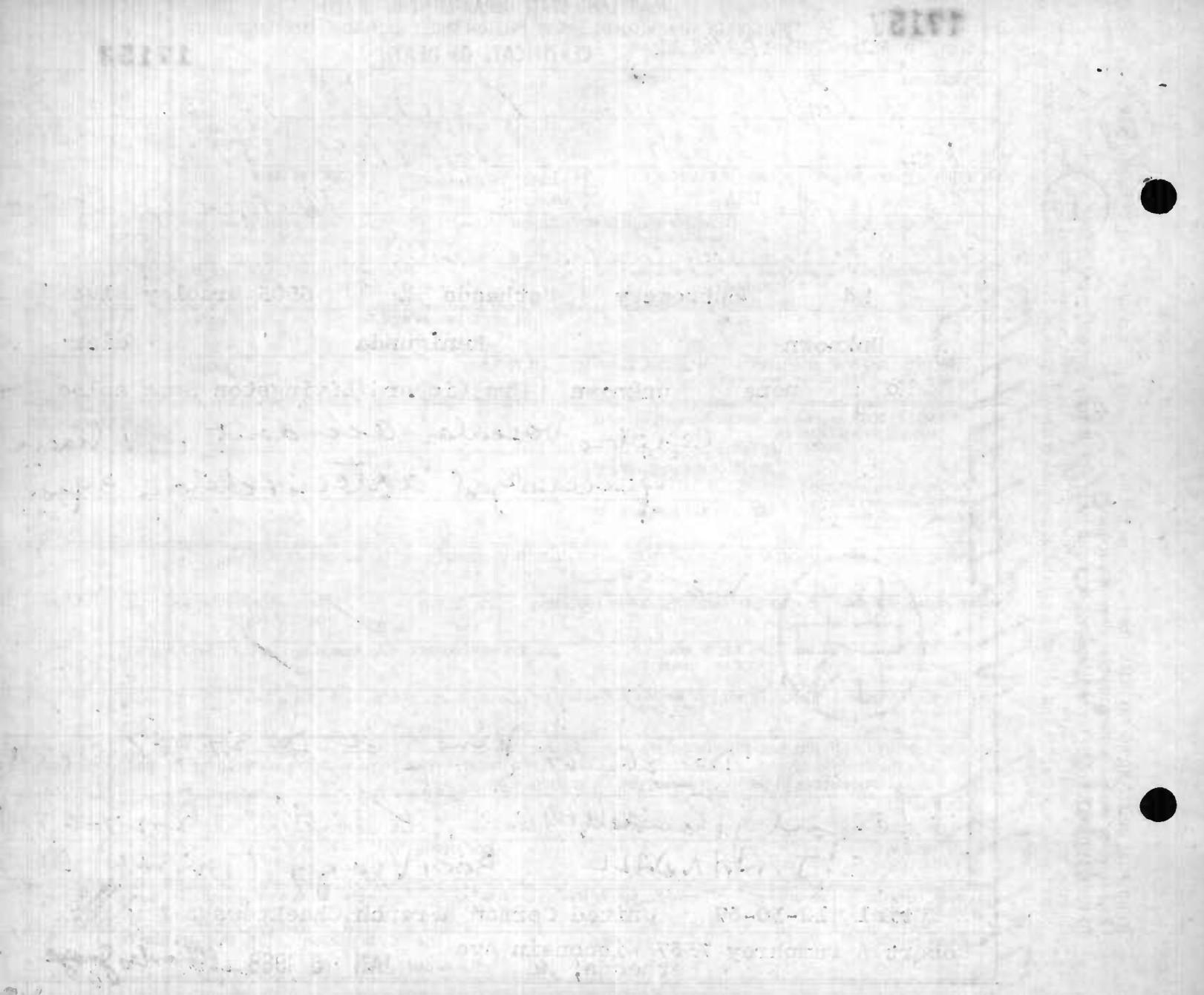


~~DO NOT FILE~~  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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17153  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 7b Film G396 1/12/68 kkCERTIFICATE OF DEATH  
17153

1. DECEASED NAME (Type or print)	First <i>Barbara</i>	Middle <i></i>	Last <i>Brosart</i>	2a. DATE OF DEATH Month <i>Dec 27</i>	Year <i>67</i>	2b. HOUR <i>2pm</i>					
3. SEX <i>Fe</i>	4. RACE <i>Wh</i>	S. DATE OF BIRTH <i>12/09/79</i>	6. AGE (In years last birthday) <i>87</i>	7. IF UNDER 1 YEAR MONTHS <i></i>			8. IF UNDER 24 HRS. HOURS <i></i>				
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery Co.</i>								
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chey Chase Nursing &amp; Convalescent Center</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Waitress</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>15.1</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>6505 Bradley Blvd</i>							
14. FATHER'S NAME First <i>Unknown</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Kunigunda</i>	Middle <i></i>	Last <i>Meier</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>none</i>	17. INFORMANT <i>Mrs Richard Livingston Same as 13e</i>	Address <i>15.1</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> <i>Cerebro Vascular Accident</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> <i></i>											
(b) <i>Generalized arteriosclerosis 3 yrs.</i>											
(c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>											
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i>		City or Town <i></i>		County <i></i>		State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1962</i> , to <i>Dec 27, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 26 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Sanford J. Randall MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>12-27-67</i>				
22d. PHYSICIAN'S NAME (Type) <i>S. J. RANDALL</i>		22e. ADDRESS <i>3001 Voyager Terr. N.W. D.C.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-30-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>United German &amp; French Cheektowaga New York</i>			23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 5 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles George</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17154

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
Montgomery MARYLAND		Maryland Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Olney		One hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Montgomery General Hospital		Silver Spring	
f. STREET ADDRESS		15-1	
3600 Glen Eagles Drive			
g. DATE OF DEATH		Month Doy Year	
13. FATHER'S NAME		12 26 1967	
Theodore Ryon		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH hours	
(b) DUE TO Declusion RT. coronary artery		years	
(c) DUE TO Generalized arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 67</u> , 19 <u>67</u> , to <u>Dec 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> 19 <u>67</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.		22b. DATE SIGNED <u>12/26/67</u>	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Richard A. Yates</u> <u>Old Baltimore Rd. Olney, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Cremation		C. Glen Carter 8434 Georgia Ave.	
Warner E. Pumphrey, Inc.		Silver Spring, Md.	
23d. LOCATION (City or Town) (County) (State)		25a. REC'D BY REGISTRAR	
Suitland, Maryland		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE JAN 4 1968			

PAGE

100

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

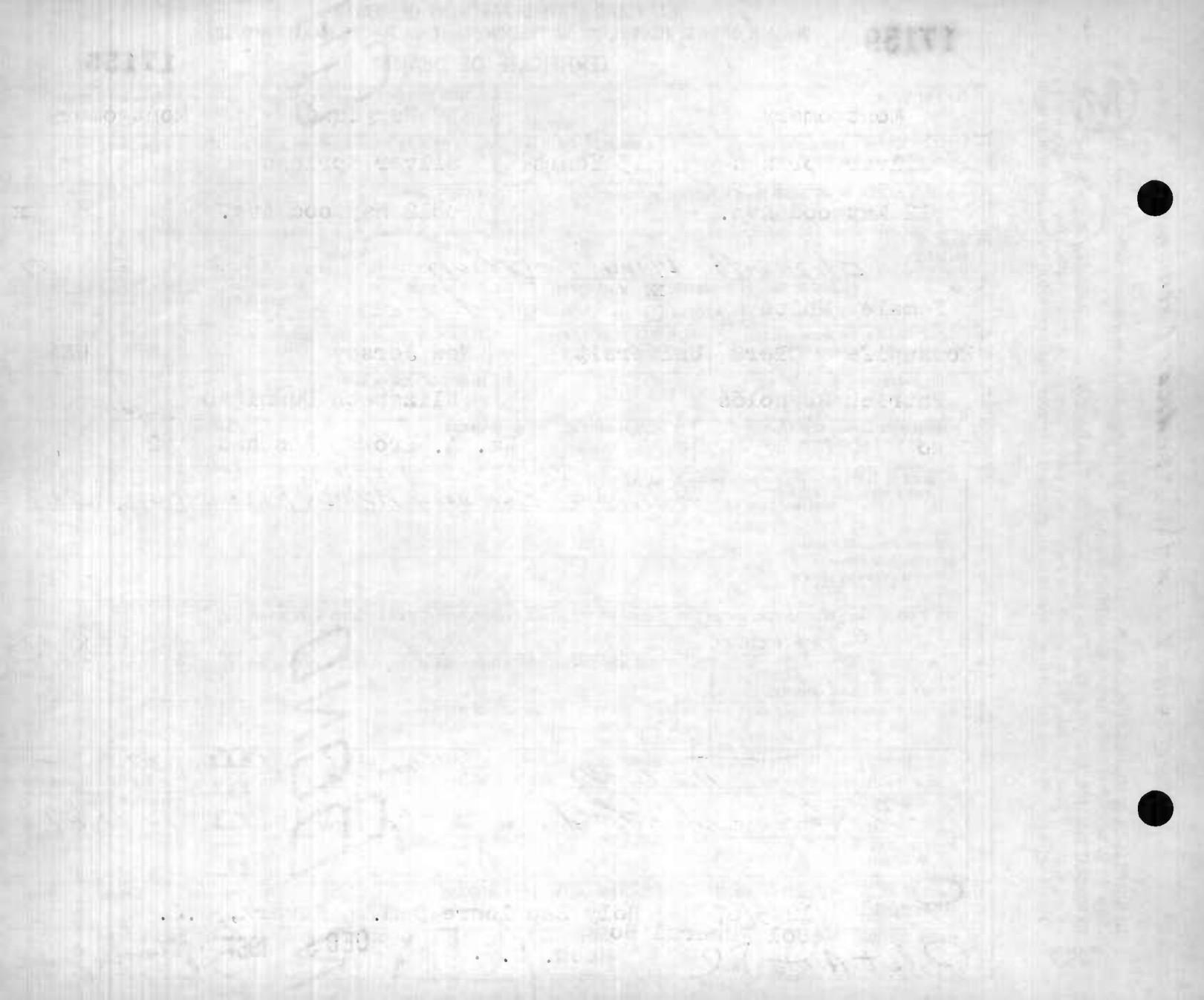
Cleared with Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17155

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs		c. LENGTH OF STAY IN lb 15 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8812 Maywood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Elizabeth</i>	Middle <i>Mary</i>	Last <i>Brown</i>
4. DATE OF DEATH	Month 12	Doy 2	Year 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Clerk	10b. KIND OF BUSINESS OR INDUSTRY University	11. BIRTHPLACE (County & State, or foreign country) New Jersey	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Patrick Reynolds	14. MOTHER'S MAIDEN NAME Elizabeth Dunnigan		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> NO	16. SOCIAL SECURITY NO.	17. INFORMANT Wm. A. Brown Husband #2	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable Coronary Artery Thrombosis</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ last. _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Cirrhosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (This hospital) attended the deceased from <i>March 1967</i> , to <i>12/2 1967</i> , that (I) (we) last saw the deceased alive on <i>11/27 1967</i> , and that death occurred at <i>9A M</i> , from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>W. Leonard Gold</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-12-67
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL BY AIR <i>cremation</i>		23b. DATE THEREOF <i>12/5/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL Holy Sepulchre Cem.
24. FUNERAL DIRECTOR <i>Devol Funeral Home</i>		23d. LOCATION (City or Town) (County) (State) Newark, N.J.	25a. REC'D. REGISTRAR <i>DEC 5 1967</i>
		ADDRESS Wash. D.C.	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		DATE	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, send in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

17160

17156

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residenc before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>19 mos 15 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Barbersberg</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>Rt 1 Box 208 Emory Grove Rd.</i>	
e. NAME OF DECEASED (Type or print) <i>Eric Lamont Brown</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Month
4. SEX	5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Dec 4, 1967</i>
8. AGE (in years last birthday) yrs.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Hours	11. Month
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery Co., Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <i>Brenda Jean Brown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Prematurity</i>	
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	
		DUE TO (c)	
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from..... and that death occurred.....		22b. DATE SIGNED	
22a. SIGNATURE <i>James A Davis Jr. M.D.</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES A DAVIS JR.</i>		22d. ADDRESS <i>8218 Wisconsin Ave, Bethesda, MD</i>	
23e. BURIAL OR CREMATION REMOVAL (Specify) <i>12/7/67</i>		23b. DATE THEREOF <i>12/7/67</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Suburban Hospital</i>		23d. LOCATION (City, town or county) <i>Bethesda - Montg. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs Amelia C. Carter, Administrator (EA)</i>		25a. REC'D BY REGISTRAR <i>DEC 11 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

DEC 11 1991

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

*10*  
*10*  
10 hours after death.  
10 hours after death.  
10 hours after death.  
10 hours after death.

17161

CERTIFICATE OF DEATH

17157

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>52 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Kermit</b>		First <b>King</b>	Middle <b>BROWN</b>
4. DATE OF DEATH <b>December 29</b>		Month <b>December</b>	Doy Year <b>29 67</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/> <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>Jul. 12, 1918</b>
9. AGE (In years last birthday) <b>49</b>	10. IF UNDER 1 YEAR Months <b>yrs.</b>	11. IF UNDER 24 HRS. Days <b>Hours</b>	12. IF UNDER 24 HRS. Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>North Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Shelby</b>		14. MOTHER'S MAIDEN NAME <b>Alice Marie Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1941-1944</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT Falls Church, Va. Address <b>Mrs. Elizabeth C. Brown, 3205 Olds Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphoma with widespread lymphatic metastases</b> INTERVAL BETWEEN ONSET AND DEATH  2021			
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____			
DUE TO  (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 7, 1967</b> , to <b>Dec. 29, 1967</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 29, 1967</b> , and that death occurred at <b>935 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE  <i>D. R. Foreman</i>		22b. DATE SIGNED <b>Dec. 30, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. R. FOREMAN, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF  23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	
24. FUNERAL DIRECTOR <i>O.M. Grauer</i> Murphy Funeral Home, 3524 Columbia Pike Arlington, Virginia		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
25a. REG'D BY REGISTRAR DATE <b>JAN 4 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

2017

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APR 10

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1971 OHIO 2002

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1971 OHIO 2002 REC'D 2017 REC'D

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17158

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Dee Clarked by Ned Gammon of Montg County - ob. Seal*

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address) <i>7344 Carroll Avenue</i>		d. STREET ADDRESS <i>7344 Carroll Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mos year</i>	First <i>S.</i>	Middle <i>Brown</i>	Last <i>12/30/67</i>
4. DATE OF DEATH Month <i>12</i> Day <i>30</i> Year <i>1967</i>	5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVDRCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>Sept 15 1879</i>	9. AGE (In years last birthday) <i>88 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Dofs <i>0</i> Hours <i>0</i> Min. <i>0</i>	11. IF UNDER 24 HRS. Months <i>0</i> Dofs <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Broker (Retired)</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Rippon West Va.</i>	12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>
13. FATHER'S NAME <i>John W. Brown</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Finell</i>	17. INFORMANT <i>Mrs. Lelia K. Montgomery (same as #2)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>577019853</i>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adams carcinoma of Prostate with Metastases.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Ch Reg. Sympathetic nerve decompr -</i>	DUE TO (b) <i></i>	DUE TO (c) <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Adelphi</i> (County) <i>Md</i> (State) <i>Md</i>		21. I certify that (I) (this hospital) attended the deceased from <i>2/6/67</i> to <i>12/30/67</i> , that (I) (we) last saw the deceased alive on <i>2/21/1967</i> , and that death occurred at <i>9:15 AM</i> , fram causes and an the date stated above.	
22a. SIGNATURE <i>H. J. Morse M.D.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>H. J. Morse M.D.</i>		22d. ADDRESS <i>7030 Carroll Ave Takoma Park Md</i>	
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Jan 2, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>George Washington Cem.</i>	23d. LOCATION (City or Town) <i>Adelphi</i> (County) <i>Md</i> (State) <i>Md</i>
24. FUNERAL DIRECTOR <i>Takoma Funeral Home J. G. Wallace</i>	ADDRESS <i>254 Carroll St Nw</i>	25a. REC'D BY REGISTRAR DATE <i>JAN 4 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

8017

MAIL

3881 MAIL

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

12163

## **CERTIFICATE OF DEATH**

17159

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		SILVER SPRING MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross</b>		d. STREET ADDRESS <b>8407 11th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LYDIA</b>		First <b>M.</b>	Middle <b>BRYANT</b>	Last <b>REED</b>	DATE OF DEATH Month Day Year <b>December 6 1967</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/1/88</b>	9. AGE (In years last birthday) <b>79 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Jonathan Bryant</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Weaver</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles W. Bryant</b> Address <b>8407 11th Ave S11 Sp</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Pneumocystis Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>few weeks</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus, late onset</b> few days. (c) <b>Generalized Arteriosclerosis</b> 1 year + Years.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1967</b> , to <b>Dec. 6, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 6 1967</b> , and that death occurred at <b>431 M</b> , fram causes and on the date stated above					
22a. SIGNATURE <b>Hugo G. Graziani</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/6/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Hugo G. Graziani, MD</b>		22d. ADDRESS <b>10101 Georgia Ave S.S., 72</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-10-1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Providence Meth. Church</b>	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland				25a. REC'D. BY REGISTRAR <b>DEC 11 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Juge</b>

2021

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

17164		17160																	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 50 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Far Rockaway		d. STREET ADDRESS 6983 Hillmyer Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital					d. STREET ADDRESS 6983 Hillmyer Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Jessie		First (none)	Middle (none)	Last BUCHANON	4. DATE OF DEATH December 3 1967		Month December	Doy 3	Year 1967	IF UNDER 1 YEAR Months Days Hours Min.									
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 25, 1925		9. AGE (In years (last birthday) 42 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Riverview, Alabama		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George Buchanon					14. MOTHER'S MAIDEN NAME Blannie Mae Wells					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1950-1967					16. SOCIAL SECURITY NO. 423 18 4595		17. INFORMANT Far Rockaway, N.Y. Address Mrs. Marion V. Buchanon, 6983 Hillmyer Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 Bronchiogenic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) last. } DUE TO } (c)					INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (A) (this hospital) attended the deceased from Oct. 18, 1967, to Dec. 3, 1967, that (B) (we) last saw the deceased alive on Dec. 3 1967, and that death occurred at 543 P.M., from causes and on the date stated above.								
22a. SIGNATURE <i>Mitchell Mills</i>					M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 5, 1967										
22c. PHYSICIAN'S NAME (Type) Mitchell Mills, M. D.					22d. ADDRESS Naval Hospital, Bethesda, Md.					23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12-7-67					23c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery		23d. LOCATION (City or Town) (County) (State) Riverview Alabama		
24. FUNERAL DIRECTOR Ward-Funeral-Home ADDRESS Falls Church					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE Fairfax--Alabama-Funeral Home, Falls Church									
Va.					DATE DEC 11 1967					Signature									

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13-1-1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1		<b>17165</b>		<b>17161</b>	
1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b MARYLAND		b. COUNTY <i>Montgomery</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washingtonian &amp; Hosp</i>		d. STREET ADDRESS <i>9316 Piney Br. Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Levett</i>		First	Middle	Lost	4. DATE OF DEATH <i>Dec 26 1967</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1896, Sept. 16</i>	9. AGE (In years last birthday) <i>71 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Europe - Lithuania</i>	
13. FATHER'S NAME <i>Chaim Kobre</i>		14. MOTHER'S MARRIED NAME <i>Rachel Gentis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-48-6029</i>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i>				INTERVAL BETWEEN DISEASE AND DEATH	
1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Carcinoma of Colon</i>		(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1967</i> , to <i>12-26, 1967</i> , that (I) (we) last saw the deceased alive on <i>12-25-1967</i> , and that death occurred at <i>Hyattsville, Maryland</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Gilbert B. Cash</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <i>X</i> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12-26-67</i>		
22c. PHYSICIAN'S NAME (Type) <i>Gilbert B. Cash</i>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-27-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Hyattsville, Maryland</i>	
24. FUNERAL DIRECTOR <i>Bernard Danzansky &amp; Sons</i> 3501 14th St. N.W. Washington, D.C. 20010		25a. RECD. BY REGISTRAR DATE <i>DEC 28 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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FOR STATE  
HEALTH DEPT.

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17166

Items 18&21 Film 396

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>20 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>RT 2, GOOD HOPE RD</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RT 2 GOOD HOPE RD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>TENCIE (NMN) BURTON</b>		First	Middle	Lost	4. DATE OF DEATH <b>Sept. 24, 1908</b>	Month <b>59</b>	Doy <b>12 - 12</b>	Year <b>1967</b>
5. SEX <b>FEMALE NEGRO</b>		6. COLOR OR RACE <b>HOUSEWIFE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1908</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>JOHN THORP</b>				14. MOTHER'S MAIDEN NAME <b>Unk.</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>DAUGHTER</b>		Address <b>SAME</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>420.1</b>		Acute coronary insufficiency with				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. <b>severe cardiomegaly and severe</b>		DUE TO (b)		severe cardiomegaly and severe				
		DUE TO (c)		intracranial atherosclerosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Belden R. Reap</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>DEC. 12, 1967</b>		
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D., Rockville</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec. 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Good Hope Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring Montg. Md.</b>		
24. FUNERAL DIRECTOR <b>Robert L. Snowden Rockville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE		
				DATE <b>DEC 21 1967</b>				

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17167

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17163

1. PLACE OF DEATH a. COUNTY <i>Montgomery Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park D.O.A</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sub-Hosp</i>		d. STREET ADDRESS <i>2409 Lyndon St</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16-2		
3. NAME OF DECEASED (Type or print) <i>Raymond Ignatius Cady</i>		First	Middle	
4. DATE OF DEATH <i>12</i>		Month	Day Year	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>3-1-23</i>		9. AGE (In years lost birthday) <i>44 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AIRWAYS OPERATIONS SPEC.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>F.A.A. Fed. Govt.</i>	11. BIRTHPLACE (State or foreign country) <i>D.C.</i>	
12. CITIZEN OF WHAT COUNTRY <i>GSA</i>		13. FATHER'S NAME <i>John Bernard Cady</i>		
14. MOTHER'S MAIDEN NAME <i>Elsie Anderson</i> Address		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i> II		
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wife</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary Artery Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH		
(b) <i>Coronary Artery Heart Disease</i>				
(c) <i>Coronary Artery Heart Disease</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i> (County) <i>Baltimore</i> (State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Baltimore, Maryland</i>		22. DATE SIGNED <i>DEC. 3, 1967</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 6, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National Cem.</i>	23d. LOCATION (City or Town) <i>Baltimore</i> (County) <i>Baltimore</i> (State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Takoma Funeral Home Takoma Park Md</i>		25. ADDRESS <i>254 Carroll St</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
6M 1/67		DATE <i>DEC 7 1967</i>		

1000 ft. above sea level  
in the valley of the  
Cerro Colorado River  
in the Andes Mountains  
Argentina

July 1930

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

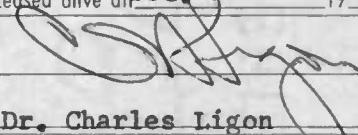
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17168

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17164

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>15811 Mt. Everest Lane</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				4. DATE OF DEATH <b>December 9 1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Giosue</b>		First <b>Joe</b>	Middle <b>Canova</b>	Lost	Month	Doy	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>12-17-01</b>	9. AGE (In years lost birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Bakery</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Switzerland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Giosue Canova</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Trippel</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-09-1804</b> Not Known		17. INFORMANT <b>Frank Greene</b>		Address <b>15811 Mt. Everest La. S.S.Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Examination of prostate</b>		DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Dec. 9 1967</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 4 1967</b> to <b>Dec. 9 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 9 1967</b> , and that death occurred at <b>6:15 AM</b> M, from causes and on the date stated above.							
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATED SIGNED <b>12-10-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Charles Ligon</b>		22d. ADDRESS <b>Medical Center, Sandy Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Dec. 10 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Warren E. Lummis, Inc.</b>		ADDRESS <b>8434 Ga Ave. S.S. Md.</b>		25a. REC'D BY REGISTRAR <b>C. Glen Carter</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
VR A15 (4) 25M 1/67				DATE <b>DEC 13 1967</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17165

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>				d. STREET ADDRESS <i>11601 Idlewood Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Hugh Dorsey Carmichael</i>		First	Middle	Last	4. DATE OF DEATH <i>December 16 1967</i>	Month	Doy	Year
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Jan. 1, 1914</i>	9. AGE (In years lost birthday) <i>53 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10. DO. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Doctors Hospital</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>A. A.</i>		
13. FATHER'S NAME <i>Hugh B. Carmichael</i>				14. MOTHER'S MAIDEN NAME <i>Effie Odem</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>254-18-7907</i>		17. INFORMANT <i>Lucille Carmichael</i>		18. ADDRESS <i>11601 Idlewood Road Silver Spring Maryland</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Acute myocardial infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>one day</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Dec 15 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 15 1967</i> , to <i>Dec 16 1967</i> that (I) (we) last saw the deceased alive on <i>Dec 15 1967</i> , and that death occurred at <i>11:00 AM</i> , from causes and on the date stated above.								
22a. SIGNATURE <i>BLAINE H. BIG</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/16/1967</i>		
22c. PHYSICIAN'S NAME (Type) <i>BLAINE H. BIG</i>		22d. ADDRESS <i>8641 Columbia Rd Silver Spring MD</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 19, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>		
24. FUNERAL DIRECTOR <i>Clark E. Warner</i>		24a. ADDRESS <i>8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>Charles Justice</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>		
25. DATE <i>DEC 28 1967</i>								

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH											
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN lb <i>2 day</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>						<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> d. STREET ADDRESS <i>1200 Clagett Dr.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> First <i>Edward</i> Middle <i>A</i> Last <i>Carter</i> (Type or print)						<b>4. DATE OF DEATH</b> Month <i>Dec</i> Day <i>26</i> Year <i>1967</i>					
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>W</i>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>3/6/1895</i>		<b>9. AGE (In years last birthday)</b> <i>72</i> yrs. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Retired</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Maryland</i>			
<b>13. FATHER'S NAME</b> <i>Benjamin Carter</i>						<b>14. MOTHER'S MAIDEN NAME</b> <i>Elizabeth Mathews</i>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <i>No</i> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <i>217-01-3774A</i>				<b>17. INFORMANT</b> Address <i>Myrtle A. Mills-daughter-same item + 2</i>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1538</i> DUE TO <i>Metastatic Ca of Colon</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <i>6 Moz.</i> lost. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. <i>19</i>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i></i>		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <i>Nov</i>, 19<i>67</i>, to <i>12-26</i>, 19<i>67</i>, that (I) (we) last saw the deceased alive on <i>12-25</i> 19<i>67</i>, and that death occurred at <i>11:30</i> AM, from causes and on the date stated above.         </b>											
<b>22a. SIGNATURE</b> <i>JMC</i>						<b>22b. DATE SIGNED</b> <i>12/26/67</i>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <i>DR. James P. McCarrick</i>				<b>22d. ADDRESS</b> <i>8218 Wisconsin Ave. Bethesda, Md.</i>							
<b>23a. BURIAL, CREMATION, BURIAL</b> <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>12/28/67</i>		<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <i>Derwood</i>				<b>23d. LOCATION (City or Town) (County) (State)</b> <i>Derwood, Maryland</i>			
<b>24. FUNERAL DIRECTOR</b> <i>Tyson Wheeler Funeral Home</i>						<b>ADDRESS</b> <i>1200 Clagett Dr. Rockville, Maryland</i>		<b>REG'D BY REGISTRAR</b> <i>JAN 2 1968</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	
<small>VR A15 (4) 25M 1/67</small>						<small>DATE</small>					

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

17171

## CERTIFICATE OF DEATH

17167

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 3 months				
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Silver Spring, 1709 Caplinger Rd.				
5. NAME OF DECEASED (Type or print)		First MARY	Middle Eileen			
6. SEX Fe		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1915			
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 10 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY Carter Const. Co.	11. BIRTHPLACE (County & State, or foreign country) UTAH.			
13. FATHER'S NAME Dilbert Nebeker		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO. Yes	17. INFORMANT Nursia & Carter 11709 Caplinger Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address Silver Spring, Md.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 170X		INTERVAL BETWEEN ONSET AND DEATH Pneumonia				
DUE TO (b)		Cerebral Metastasis				
DUE TO (c)		Carcinoma Breast				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Prince Georges Co.	(County) Md.	(State)
21. I certify that (I) (this hospital) attended the deceased from 1964, 19 to 12-10, 1967, that (I) (we) last saw the deceased alive on 12-10 1967, and that death occurred at 230 P.M., from causes and on the date stated above.						
22a. SIGNATURE Robert Kramer		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE/SIGNED 12/10/67.	
22c. PHYSICIAN'S NAME (Type) ROBERT KRAMER		22d. ADDRESS 8484 16th St. 88 Nd.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 10, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Port Lincoln Crematory	23d. LOCATION (City or Town) Prince Georges Co. Md.		
24. FUNERAL DIRECTOR Clark E. Wiggin Warner E. Pumphrey, Inc.		ADDRESS 18034 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE DEC 13 1967	25b. REGISTRAR'S SIGNATURE Judge	

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm files. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G396 7/12/68 10k

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17168

FOR STATE  
HEALTH DEPT.

17172

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>15 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suburbian</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>8313 Garland Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Florence N.</i>	Middle <i>Castle</i>	4. DATE OF DEATH <i>Dec. 27</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>3/25/1977</i>
9. AGE (In years last birthday) <i>70 yrs.</i>		9. IF UNDER 1 YEAR Months <i>0</i> Dots <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Nursing</i>		11. BIRTHPLACE (State or foreign country) <i>W. VA.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>P. Z. Castle</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA SELLERS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hosp. RECORDS</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, old &amp; recent, anterior left ventricle and interventricular septum</i> DUE TO <i>9047</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>marked coronary arteriosclerosis</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>48 hr.</i>			
7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture of Right Hip.</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell in nursing home causing fracture of Rt hip.</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>12/25 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>nursing home -</i>
20f. (City or town) <i>Holmeson-Montgomery Md.</i>		(County) <i>Montgomery</i> (State) <i>MD.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i>BETHESDA, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-1-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Glover Cemetery</i>
23d. LOCATION (City or Town) <i>Glover Gap</i> (County) <i>Wetzel</i> (State) <i>W. Va.</i>			
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey, 7557 Wisconsin Ave.</i>		25a. REC'D BY REGISTRAR ADDRESS <i>Bethesda, Md.</i> DATE JAN 5 1968	
		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M		17173		17169	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		3. NAME OF DEATH First Middle Last	
Montgomery Maryland		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		b. COUNTY	
b. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San & Hosp.		d. STREET ADDRESS 7313 Flower Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year		5. SEX	
Bertha E. ? Chapin		December 26 1967		F W	
6. COLOR OR RACE		7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 8-1877	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		9. AGE (In years lost birthday) 90 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S. A		13. FATHER'S NAME Dwight Anderson	
14. MOTHER'S MAIDEN NAME Clarassia Rockwell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-07-2813	
17. INFORMANT Eugene R. Chapin 2611 Kinderbrook Lane R Med Records Bowie, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6051 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ch. Memes (c) Acute Cystitis		19. INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20c. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 12/18, 1967, to 12/26, 1967, that (I) (we) last saw the deceased alive on 12/20/1967, and that death occurred at M, from causes and on the date stated above.		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE H. T. Morse		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) H. T. Morse		22d. ADDRESS 7030 Carrollton Takoma Park Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF Dec 30, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Port Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR John B. Thomas, Glazeborn, 8434 Georgia Avenue Warren E. Pumphrey, Inc. Silver Spring, Maryland		25a. ADDRESS 8434 Georgia Avenue		25b. REC'D BY REGISTRAR DATE JAN 2 1968	
25c. REGISTRAR'S SIGNATURE Charles Judge					

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17174

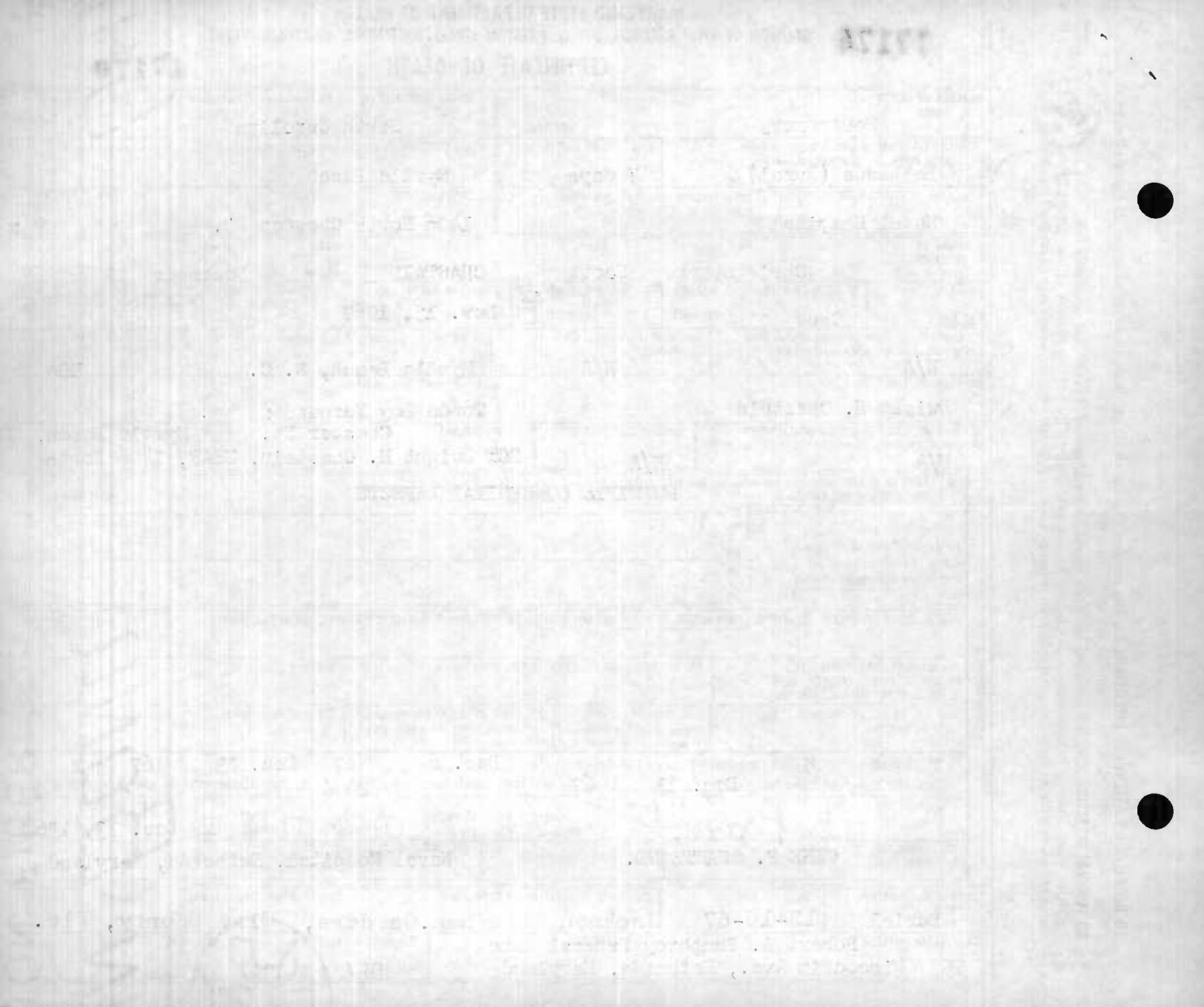
## CERTIFICATE OF DEATH

17170

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>South Carolina</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Myrtle Beach</b>		d. STREET ADDRESS <b>1406 North Chester St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Christopher Scott</b>		First	Middle
4. DATE OF DEATH <b>CHASTAIN</b>		Month	Day
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Nov. 15, 1967</b>		9. AGE (In years lost birthday) yrs. <b>28</b>	IF UNDER 1 YEAR Months <b>28</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Myrtle Beach, S. C.</b>
13. FATHER'S NAME <b>Dwight H. Chastain</b>		14. MOTHER'S MAIDEN NAME <b>Tonda Loy Fernandez</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	17. INFORMANT Chester St. Address Myrtle Beach, SC SGT Dwight H. Chastain, USAF, 1406 North
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7593</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ lost. DUE TO (c) _____			
MULTIPLE CONGENITAL DEFECTS INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>Dec. 6, 1967</b> , to <b>Dec. 13, 1967</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>Dec. 13, 1967</b> , and that death occurred at <b>240A M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>Dec. 13, 1967</b>	
22a. SIGNATURE <b>Gene P. Swartz</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>GENE P. SWARTZ MD.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-16-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Jacksonville Mem. Gardens, Clay County, Fla.</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 18 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>
7557 Wisconsin Ave., Bethesda, Maryland			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or offending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>								17171				
<b>1. PLACE OF DEATH</b> a. COUNTY      Montgomery      MARYLAND				<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE      Maryland      b. COUNTY      Prince Georges								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 159 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS 5564 Maxwell Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> First      Ireda      Middle      June      Last      Christiansen				<b>4. DATE OF DEATH</b> Month      December      Day      5      Year      1967								
<b>S. SEX</b> Female      White		<b>6. COLOR OR RACE</b> WIDOWED      DIVORCED		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> May 19, 1942		<b>9. AGE (In years last birthday) yrs.</b> 25				
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> Housewife			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> --			<b>11. BIRTHPLACE (Country &amp; State, or foreign country)</b> California			<b>12. CITIZEN OF WHAT COUNTRY?</b> USA			
<b>13. FATHER'S NAME</b> James Harris				<b>14. MOTHER'S MAIDEN NAME</b> Myrtle Blodgett								
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)			<b>16. SOCIAL SECURITY NO.</b>			<b>17. INFORMANT</b> The Medical Records Address Not available      The Clinical Center, Bethesda, Maryland						
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a)      Congestive heart failure								<b>INTERVAL BETWEEN ONSET AND DEATH</b> 18 hours				
2043 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Multiple pulmonary emboli								1 month				
(c) Acute myelogenous leukemia								6 months				
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> Hepatic failure, probable drug toxicity (weeks)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> 5		<b>(County)</b>		<b>(State)</b>		
<b>21. I certify that</b> (1) (this hospital) attended the deceased from June 29, 1967, to December 1, 1967, that (1) (we) last saw the deceased alive on December 5, 1967, and that death occurred at 6:03 M, from causes and on the date stated above.												
<b>22a. SIGNATURE</b> 				M.D.      ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				<b>22b. DATE SIGNED</b> 5 December 1967				
<b>22c. PHYSICIAN'S NAME (Type)</b> David L. Lilien, MD				<b>22d. ADDRESS</b> The Clinical Center, National Institutes of Health, Bethesda, Md.								
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>23b. DATE THEREOF</b> 12/11/67		<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> Mt. View Memorial Pk. Cemetery, Tacoma, Washington				<b>23d. LOCATION (City or Town)</b> Tacoma, Washington				
<b>24. FUNERAL DIRECTOR</b> Robert E. Wilhelm Funeral Home ADDRESS 4308 Suitland Road, Suitland, Maryland				<b>25a. REC'D BY REGISTRAR</b> DATE DEC 11 1967				<b>25b. REGISTRAR'S SIGNATURE</b> 				

STET

John C. Smith

FOR STATE  
HEALTH DEPT.

17176  
1  
M  
PM  
Page

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17172

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE							
<i>Montgomery Maryland</i>		<i>70d. Mont.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
<i>Bethesda</i>		<i>151</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS							
<i>Suburban</i>		<i>5209 Wilson Lane</i>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle						
<i>Thomas</i>		<i>C</i>	<i>hristison</i>						
4. DATE OF DEATH		Month	Day						
<i>12-29</i>		<i>1967</i>							
5. SEX		6. COLOR, OR RACE	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH	10. AGE (In years last birthday)	11. IF UNDER 1 YEAR Months Days Hours Min.	12. IF UNDER 24 HRS. Hours Min.	
<i>m</i>		<i>gr</i>	<i>Widowed</i>	<input checked="" type="checkbox"/>	<i>12-6-57</i>	<i>10 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>Student</i>				<i>Germany</i>		<i>U.S.A.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.			
<i>William A. Christison</i>		<i>Katherine Talbot</i>		<i>If yes give war or dates of service)</i>		<i>17. INFORMANT</i>  <i>Mother-Katherine -</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ASPHYXIA		INTERVAL BETWEEN ONSET AND DEATH			
<i>9294</i>		DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO  <i>Drowning -</i>		<i>3 min?</i>			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>11:25 am 12/29 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Swimming Pool</i>	
				20f. (City or town) (County) (State)		<i>Bethesda Montgomery Md</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspectian <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED							
ACTUAL SIGNATURE <i>John G. Bell</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIY		23d. LOCATION (City or Town)		(County) (State)	
<i>Cremation</i>		<i>12/30/67</i>		<i>Ft. Lincoln Cemetery</i>		<i>Colmaux Manoy PC MD</i>			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<i>F. Gasch's Sons Hyattsville, Md</i>									
VR A15ME (5) 6M 1/67				DATE JAN 4 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

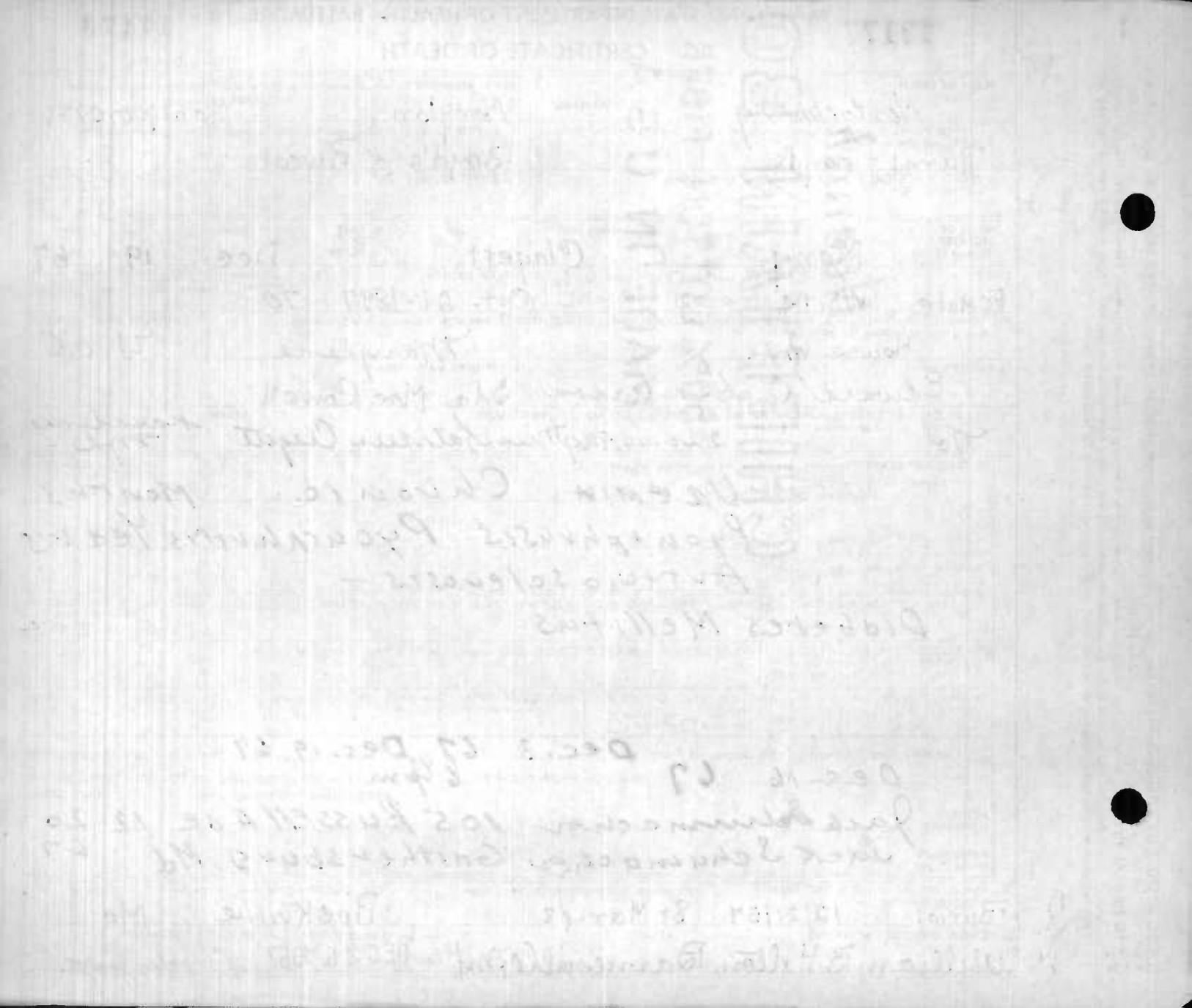
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17173

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i>	b. COUNTY <i>Montgomery</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Boyd's</i>	c. LENGTH OF STAY IN 1b <i>Boyd's - Rural</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boyd's - Rural</i>	d. STREET ADDRESS <i>157</i>
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Mary</i>	First <i>L</i>	Middle <i>Clagett</i>	Last <i></i>
4. DATE OF DEATH Month <i>Dec.</i>	Day <i>19</i>	Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 21-1897</i>
9. AGE (In years lost birthday) 70 yrs.	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Edward O. Henderson</i>	14. MOTHER'S MAIDEN NAME <i>Ida Mae Cowell</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>220-44-8169</i>	INFORMANT <i>Miss Kathleen Clagett</i>	Address <i>Pasadena Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500</i>	DUE TO <i>UREMIA - Chronic</i>	INTERVAL BETWEEN ONSET AND DEATH <i>Months</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	DUE TO <i>Pyonephrosis - Pyonephrosis Years</i>		
(c) <i>Diabetes Mellitus</i>	Auteviosclerosis -		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Dec. 3, 1967</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 3, 1967</i> to <i>Dec. 19, 1967</i> , that I last saw the deceased alive on <i>Dec. 16, 1967</i> , and that death occurred at <i>6 p.m.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>105 Russell Ave 12-20-</i>			DATE SIGNED <i></i>
ACTUAL SIGNATURE <i>Jack Schumacher M.D.</i>	PHYSICIAN'S NAME (Type) <i>Jack Schumacher</i>	Gaithersburg, Md <i>67</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/21/67</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Mary's</i>	22d. LOCATION (City, town, or county) (State) <i>Rockville Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hilton, Barnesville, Md</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE DEC 26 1967	24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17174

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, from this certificate. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE					
Montgomery MARYLAND		Maryland Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Renssington		Wheaton 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS					
Kensington Gardens Sanitorium		3700 Hardy Avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle				
Beulah		Anna	Clarke				
4. DATE OF DEATH	Month	Day	Year				
Dec. 19	19	19	67				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH May 16 1880	9. AGE (In years lost birthday) yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
F	W			87	Own Home	Maryland	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
James F. Hardy	May E. Sheehy						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address				
No	217-52-8103	John H. Hardy	7200 Hilton Avenue Jacobs Park, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary edema					INTERVAL BETWEEN ONSET AND DEATH
493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Pneumonia					2 days
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
generalized arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/67, 19, to 12/19/67, 19, that (I) (we) last saw the deceased alive on 12/18/67, 19, and that death occurred at 5:35PM, from causes and on the date stated above.							
22a. SIGNATURE		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED				
Patrick C. Jameson			12/19/67				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
Patrick C. Jameson		11718 Georgia Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town)	(County)	(State)
Burial		Dec. 22, 1967	Arlington National		Arlington, Virginia		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Walter R. Thompson, Inc.		8434 Georgia Avenue		DEC 27 1967	Charles Judge		

ESTATE

John C. Dillinger  
John Wesley Dillinger  
John Wesley Dillinger  
John Wesley Dillinger

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

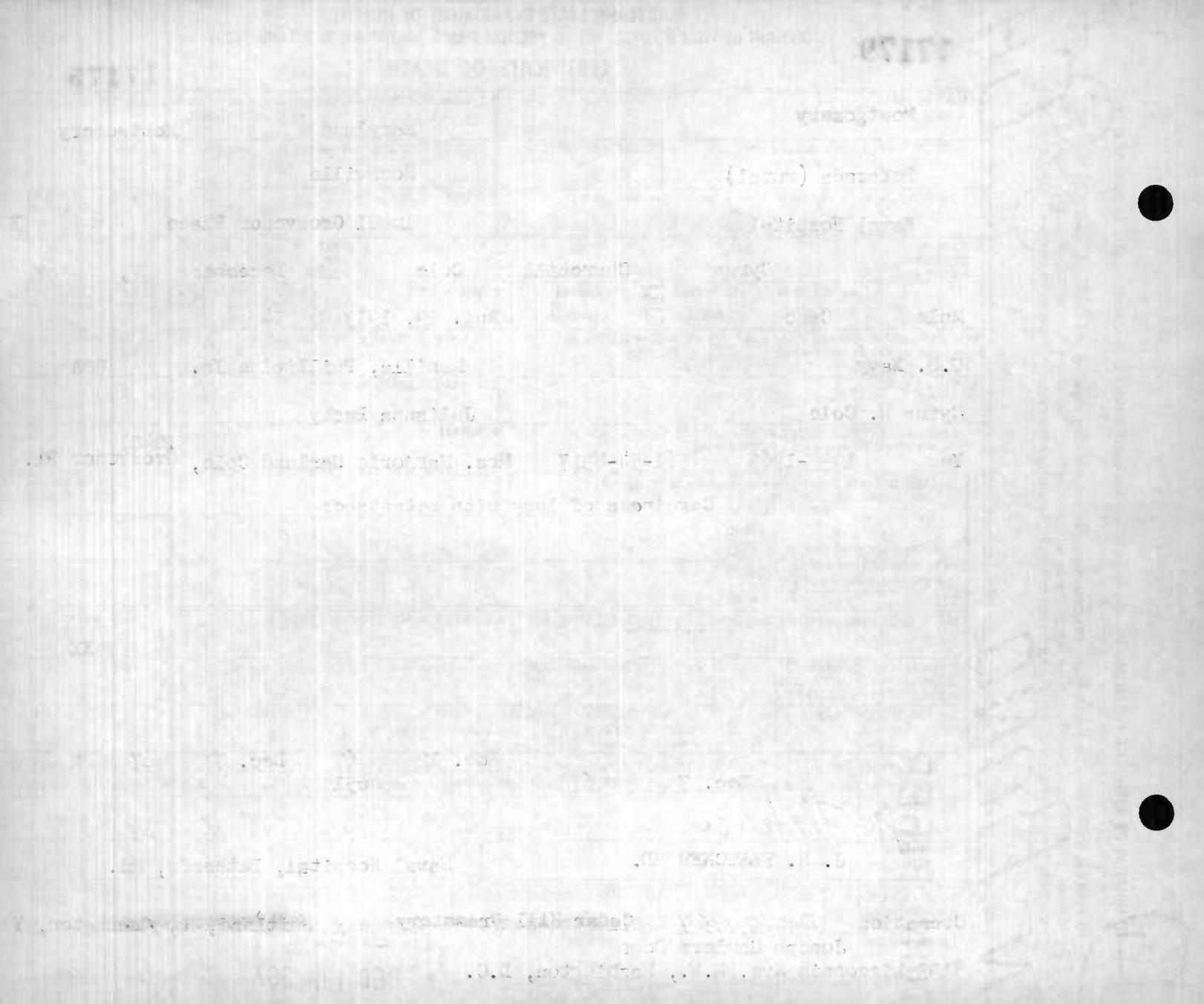
17179

CERTIFICATE OF DEATH

17175

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>10401 Grosvenor Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Cyrus</b>	Middle <b>Churchill</b>	Last <b>Cole</b>
4. DATE OF DEATH Month <b>December</b>	Year <b>7, 1967</b>	Doy	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1913</b>
9. AGE (In years lost, birthday) <b>54 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Manilla, Phillipine Is.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Cyrus W. Cole</b>	14. MOTHER'S MAIDEN NAME <b>Julianna Busby</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1935-1965</b>	16. SOCIAL SECURITY NO. <b>561-54-8317</b>	17. INFORMANT <b>Mrs. Marjorie Garland Cole,</b>	Address <b>10401 Grosvenor Pl.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung with metastases</b>			INTERVAL BETWEEN ONSET AND DEATH
163 X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 12, 1967</b> , to <b>Dec. 7, 1967</b> , that (A) (we) last saw the deceased alive on <b>Dec. 7, 1967</b> , and that death occurred at <b>0515 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>JR Fletcher</b>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>8 Dec 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. R. FLETCHER MD.</b>	22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>Dec. 9, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland, Va.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawlers Sons</b>	ADDRESS <b>5133 Wisconsin Ave. N.W., Washington, D.C.</b>	25a. RECD BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

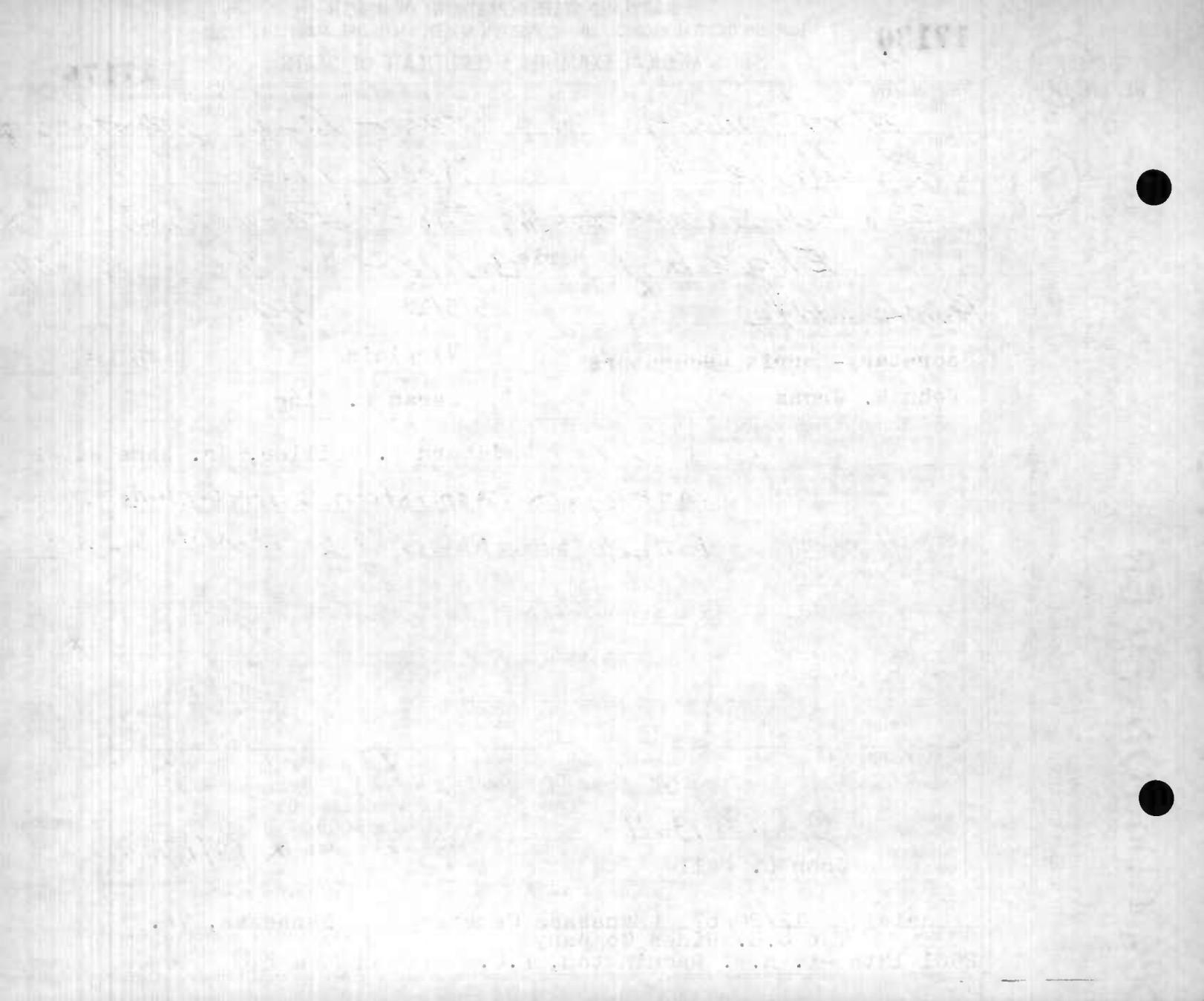
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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17176

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		<i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>338-W. Edmonston St.</i>		d. STREET ADDRESS <i>338-W. Edmonston St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Elizabeth</i>	Middle <i>Marie</i>
3. NAME OF DECEASED (Type or print)		Last <i>Collier</i>	4. DATE OF DEATH <i>Dec. 16 1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/5/18</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary-Morris Decorators</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John W. Cross</i>		14. MOTHER'S MAIDEN NAME <i>Sarah M. King</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wilburn P. Collier, Jr. same as #2</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASphyxia - Aspiration. Gastric Contents. Smith</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>581.0</i> (b) <i>Fatty Metamorphosis of Liver-Acute.</i> 2 hr?			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>12/17/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>12/20/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Manassas Cemetery</i>
23d. LOCATION (City or Town) (County) (State) <i>Manassas, Va.</i>			
24. FUNERAL DIRECTOR <i>The S.H. Hines Company</i> 2901 14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR DATE <i>DEC 20 1967</i>	25b. REGISTRAR'S SIGNATURE <i>John G. Ball</i>



FOR STATE  
HEALTH DEPT.Items 18&21 Film 396  
1-15-68 ams MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17181

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17177

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		d. STREET ADDRESS <b>Rt. 4</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>James</b>	Middle <b>Edwin</b>	Last <b>Combs</b>	4. DATE OF DEATH <b>12</b>	Month <b>12</b>	Day <b>30</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>WIDOWED</b>	NEVER MARRIED <b>Divorced</b>	8. DATE OF BIRTH <b>06/18/11</b>	9. AGE (In years last birthday) <b>56 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Odd jobs</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Combs</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Cain</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>236-14-6877</b>		17. INFORMANT <b>Harold Combs</b> 2208 Pleasant View Cantonville 28, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) DUE TO								
Acute coronary insufficiency due to Arteriosclerotic heart disease								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension; Chronic Ethylism</b>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Towson</b>	(County) <b>Howard</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address, State, or county <b>Towson</b> DEC. 31, 1967						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-4-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Good Shepherd</b>		23d. LOCATION (City or Town) <b>Ellicott City</b> (County) <b>Howard</b> (State) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>Hughes - Slack</b>		ADDRESS <b>Ellicott City, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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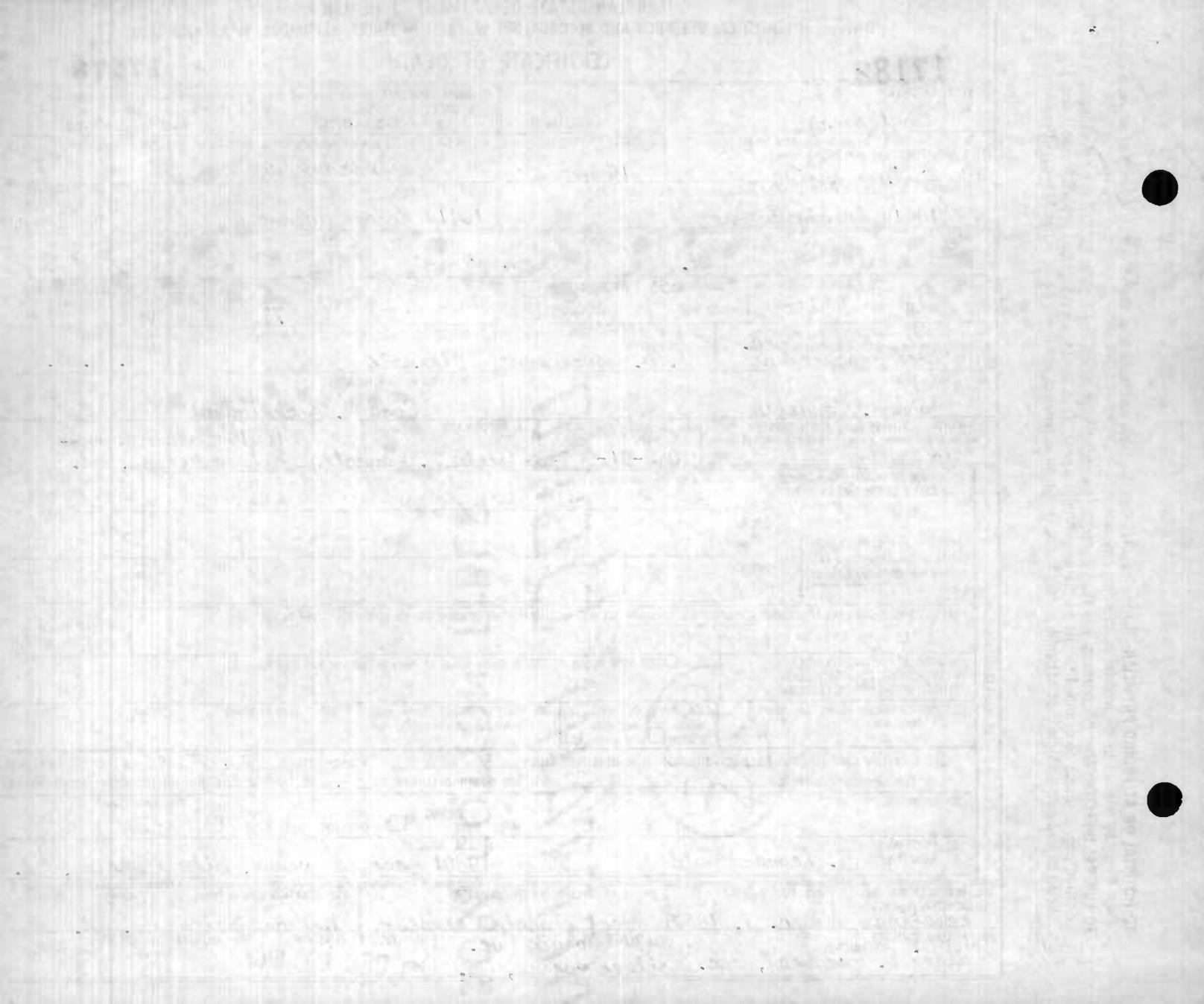
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

17182		17178	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>19 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>10414 Lorain Avenue</i>		d. STREET ADDRESS <i>10414 Lorain Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Jack H. Connally</i>		First	Middle
4. DATE OF DEATH Month <i>12</i> Day <i>7</i> Year <i>1967</i>		Last	Connally
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 12, 1894</i>
9. AGE (In years lost birthday) <i>73 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Procurement</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John H. Connally</i>		14. MOTHER'S MAIDEN NAME <i>Cora M. Bickelhaupt</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>082-01-0094</i>	
17. INFORMANT <i>A Greta L. Connally</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myelogenous Leukemia</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs 6 mos</i>	
DUE TO <i>2041</i>		(b) _____	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <i>storing the underlying cause</i>		DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary Artery Disease</i>			
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/25</i> , 19 <i>65</i> , to <i>12/12</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12/16</i> , 19 <i>67</i> , and that death occurred at <i>3A</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>G. Leonard Gold</i>		22b. DATE SIGNED <i>12/17/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>G. Leonard Gold</i>		22d. ADDRESS <i>9801 Georgia Avenue, Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Dec. 7, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co. Md.</i>	
24. FUNERAL DIRECTOR <i>John B. Rogers &amp; Sons Home 8434 Georgia Ave. Warren E. Humphrey, Inc. Silver Spring, Md.</i>		25a. ADDRESS <i>8434 Georgia Ave.</i>	
		25b. REC'D BY REGISTRAR <i>Charles Judge</i>	
		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR  
 death. Page 4  
 be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-tent permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. VR A15 (4) 15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

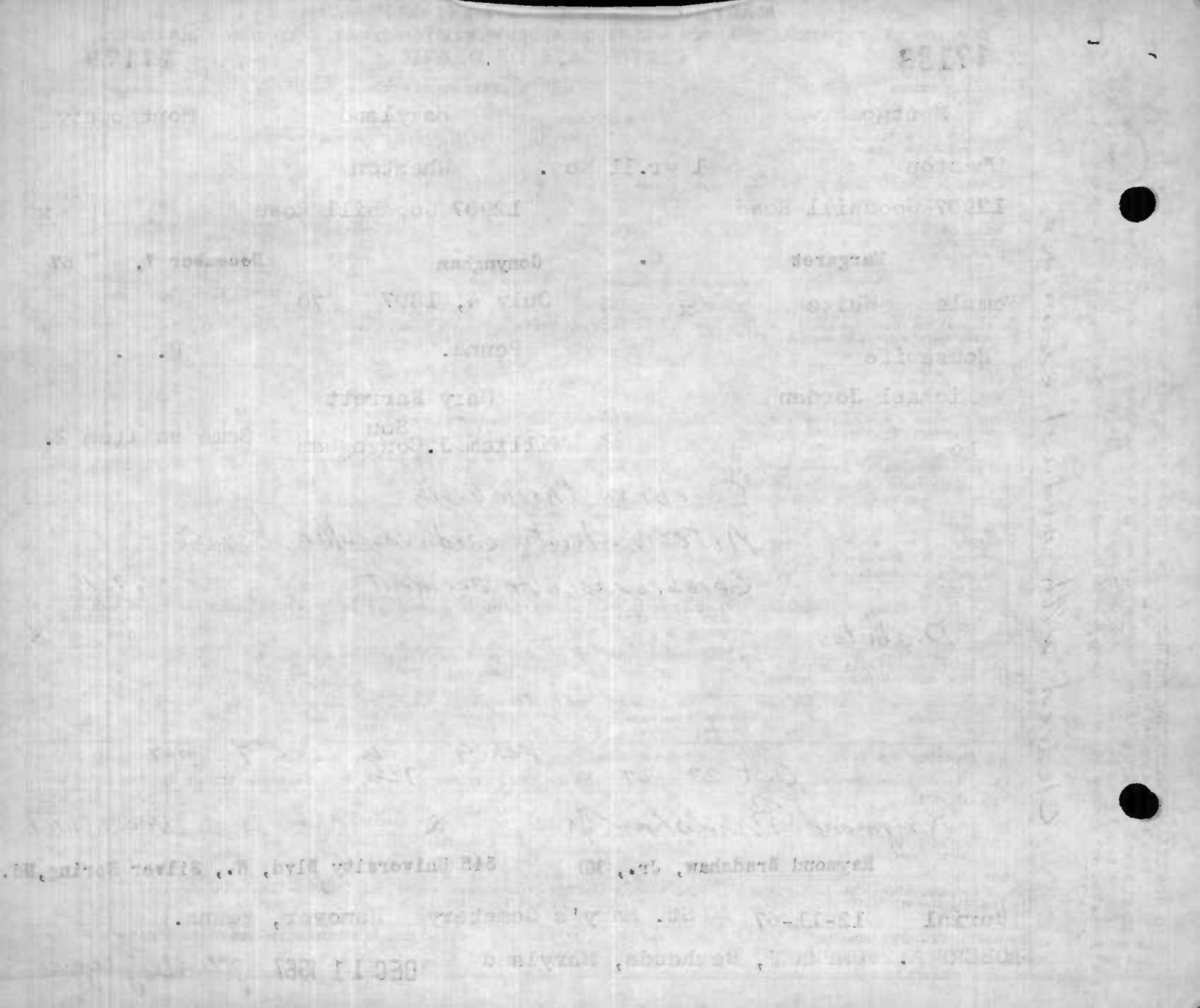
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17183

17179

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>1 yr. 11 Mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>12907 Goodhill Road</b>		d. STREET ADDRESS <b>12907 Goodhill Road</b>	
3. NAME OF DECEASED (Type or print) <b>Margaret</b>		First <b>E.</b>	Middle <b>Conyngham</b>
Last <b>Conyngham</b>		4. DATE OF DEATH <b>December 7, 1967</b>	Month Day Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>July 4, 1897</b>		9. AGE (In years last birthday) <b>70 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Michael Jordan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Barrett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Son</b>		Address <b>William J. Conyngham</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Cerebrovascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1961</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 9, 1966</b> , to <b>Dec. 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 27, 1967</b> , and that death occurred at <b>750 M</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>Dec. 7, 1967</b>	
22a. SIGNATURE <b>Raymond Bradshaw, Jr., M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>345 University Blvd, W., Silver Spring, Md.</b>
22c. PHYSICIAN'S NAME (Type) <b>Raymond Bradshaw, Jr., MD</b>		23d. LOCATION (City, town or county) (State) <b>Hanover, Penna.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-11-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Mary's Cemetery</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS 25a. REC'D BY REGISTRAR DATE <b>DEC 11 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17184

17180

Item #7 Film #0396 12/26/67

1. PLACE OF DEATH  
a. COUNTY

MONTGOMERY

MARYLAND

## b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

KENSINGTON

## c. LENGTH OF STAY IN 1b

1 Mo - 9 1/2

## d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

KENSINGTON GARDENS

3. NAME OF  
DECEASED  
(Type or print)First  
OTHOMiddle  
B.Last  
COOLEY4. DATE  
OF  
DEATH

DEC.

12 -

1967

## 5. SEX

MALE

## 6. COLOR OR RACE

WHITE

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

APRIL 10-78

9. AGE (In years  
last birthday)

89 yrs.

## 10. IF UNDER 1 YEAR

Months Days Hours Min.

## 11. BIRTHPLACE (County &amp; State, or foreign country)

MONTGOMERY Co. Md. U.S.A.

12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME

RICHARD COOLEY

## 14. MOTHER'S MAIDEN NAME

LOUISE AUSTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

## 16. SOCIAL SECURITY NO.

519-12-1291

## 17. INFORMANT

Family of the deceased (same as above)

## Address

INTERVAL BETWEEN  
ONSET AND DEATH

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

4201

## DUE TO

Conditions, If any, which  
gave rise to Immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO

(c)

Myocardial Dystrophy

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. MEDICAL CERTIFICATION  
ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)  
20d. INJURY OCCURRED While Not White  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)Hour a.m.  
p.m. 19at work  at work 

12-11, 1967 to 12-12, 1967

1967, and that death occurred at 2:30 pm, from the causes and on the date stated above.

21. I certify that (I) (this hospital) attended the deceased from 12-11, 1967 to 12-12, 1967, that (I) (we) last  
saw the deceased alive on 12-11, 1967, and that death occurred at 2:30 pm, from the causes and on the date stated above.

## 22a. SIGNATURE

Robert T. Thibadeau, M.D.

## 22b. DATE SIGNED

12-12-67

22c. PHYSICIAN'S  
NAME (Type)

## 22d. ADDRESS

11000 Old Georgetown Rd.  
Rockville, Maryland23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial Dec 15, 1967

## 23b. DATE THEREOF

Monocacy Cemetery, Beallsville, Md.

## 23c. NAME OF CEMETERY OR CREMATORIUM

## 24. FUNERAL DIRECTOR

Arthur Walters

23d. LOCATION (City, town or county)  
(State)

T. J. Carroll &amp; Son, Inc., Charles Judge

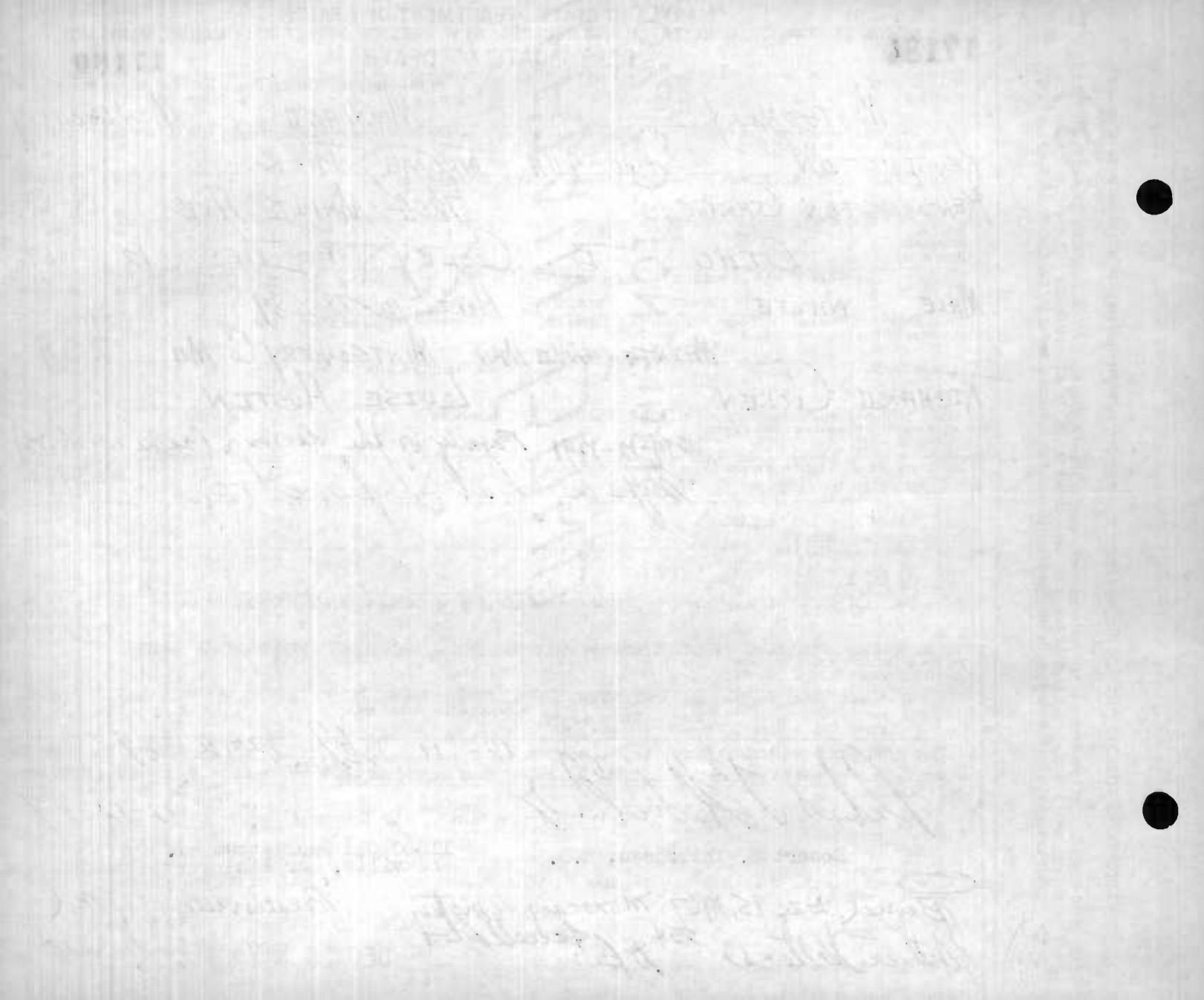
## 25a. REC'D BY REGISTRAR

DATE DEC 18 1967

## 25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17185

CERTIFICATE OF DEATH

17181

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland</b>		d. STREET ADDRESS <b>20777</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph</b>		First <b>Joseph</b>	Middle <b>Ernest</b>	Last <b>Cooney</b>	4. DATE OF DEATH <b>12 23 1967</b>	Month <b>12</b>	Day <b>23</b>	Year <b>1967</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/28/06</b>	9. AGE (In years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed-disabled</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John J. Cooney</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. French</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records, Olney, Maryland</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5810</b>		IMMEDIATE CAUSE (a) <b>acute cardiac failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <b>Chronic congestive cardiac failure</b>				2 years			
		DUE TO (c) <b>Cirrhosis of the liver</b>				10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>Lobar pneumonia, rt lower lung</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Clarksville</b>		(County) <b>Maryland</b>	(State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>12/15 1967</b> to <b>12/23 1967</b> , that (I) (was) lost saw the deceased alive on <b>12/22 1967</b> , and that death occurred at <b>3:23 PM</b> from causes and on the date stated above.									
22a. SIGNATURE <b>Charles S. Whitaker,</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/24/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>		22d. ADDRESS <b>Clarksville, Maryland 21029</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-27-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Union</b>		23d. LOCATION (City or Town) (County) (State) <b>Burtonsville, Mont., Md.</b>			
24. FUNERAL DIRECTOR <b>Higinbotham-Slack John Resnick</b>		ADDRESS <b>Fellsmere City</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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*10*  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

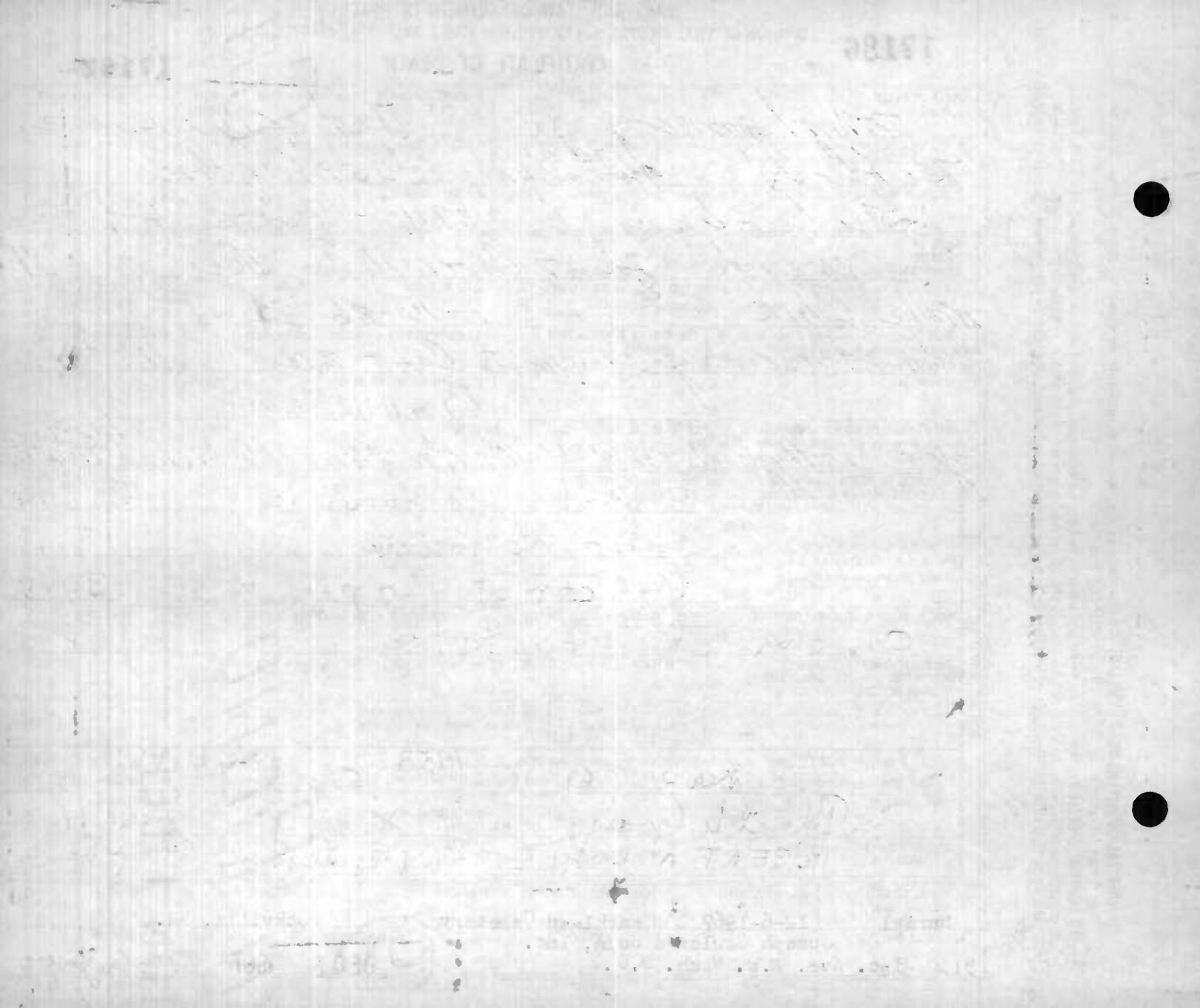
*17186*

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

*17182*

1. PLACE OF DEATH o. COUNTY <i>Montgomery Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Dist. of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Maryland</i>		c. LENGTH OF STAY IN 1b <i>13 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
3. NAME OF DECEASED (Type or print) <i>Walter Hunt Cottrell</i>		First <i>W</i>	Middle <i>H</i>
Last <i>Cottrell</i>		4. DATE OF DEATH <i>Dec. 2</i>	Month Day Year <i>Dec. 2 1967</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-14-86</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Master Miler</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>government</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Colorado</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>-</i>	14. MOTHER'S MAIDEN NAME <i>Charlotte Tabor</i>	Address <i>11509</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>yes</i>	16. SOCIAL SECURITY NO. <i>578-62-2616</i>	17. INFORMANT <i>Walter Hunt Cottrell</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>161X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Tuberculosis</i>		19. UNDERLYING CAUSE <i>Bronchitis</i>	
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Traumatic</i>		20. UNDERLYING CAUSE <i>Cancer of Larynx</i>	
(c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Cancer of Prostate</i>		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <i>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1953</i> to <i>Dec 2 1967</i> that (I) (we) last saw the deceased alive on <i>Dec 2 1967</i> , and that death occurred at <i>7:15 A.M.</i> from causes and on the date stated above		22b. DATE SIGNED <i>Dec 3, 1967</i>	
22a. SIGNATURE <i>Robert N. Coale</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>ROBERT N. COALE</i>		22d. ADDRESS <i>4429 Bradley Lane Chevy Chase Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-6-1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Parklawn Cemetery</i>
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		25a. RECE'D BY REGISTRAR <i>DATE DEC 5 1967</i>	25b. REGISTRAR'S SIGNATURE <i>John G. Gandy</i>
5130 Wisconsin Ave. N.W. Wash. D.C.			

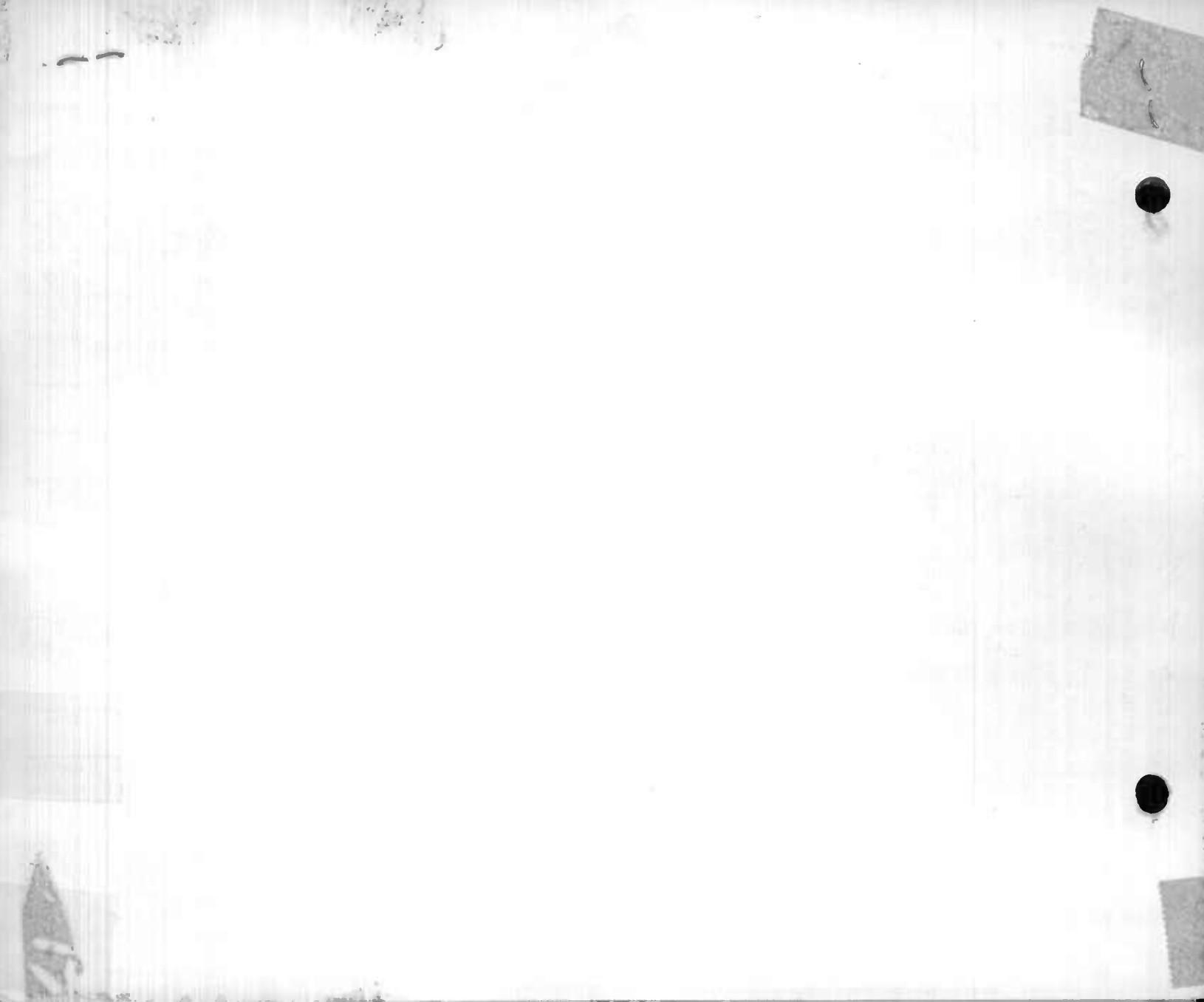


## Cleared to Medical Examiner, L.S.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>			b. COUNTY <b>PRINCE GEORGE</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>			c. LENGTH OF STAY IN lb <b>DOA</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>			d. STREET ADDRESS <b>7514 JACKSON AVE.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN &amp; HOSP.</b>									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>IDA ANN CRAFT</b>			First	Middle	Last	4. DATE OF DEATH <b>12 - 30</b>			Month	Doy	Year <b>1967</b>			
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>02-12-81</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			11. BIRTHPLACE (County & State, or foreign country) <b>ILLINOIS</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>LESLIE DOPPELMAN</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE BATCHLOR</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NONE</b>			16. SOCIAL SECURITY NO. <b>NONE</b>			17. INFORMANT <b>DR. EVELYN GREER - SAME</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Congestive failure</b> DUE TO (c) <b>Hypertension</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>0 yrs</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 to <b>1967</b> , 19, that (I) (we) last saw the deceased alive on <b>Nov 5</b> , 1967, and that death occurred at <b>934 M.</b> from causes and on the date stated above.						22b. DATE SIGNED								
22a. SIGNATURE <i>[Signature]</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) <b>Chas H. Wootton</b>			22d. ADDRESS <b>1401 Blair Rd. Silver Spring, Md.</b>			23d. LOCATION (City or Town) <b>Glenelg, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Jan. 4, 1968</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Linwood Cemetery</b>			23d. LOCATION (City or Town) <b>Glenelg, Md.</b>					
24a. GENERAL DIRECTOR <b>C. Glen Carter</b>			24b. ADDRESS <b>3434 Warner E. Pumphrey, Inc. Silver Spring, Md.</b>			25a. REC'D BY REGISTRAR <b>N. J. B. 800</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>9 hours</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>5003 Alta Vista Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Susan R. Crymes</i>		First <i>Susan</i>	Middle <i>R.</i>
Last <i>Crymes</i>		4. DATE OF DEATH Month <i>December</i>	Day Year <i>18 1967</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>9-6-03</i>		9. AGE (In years last birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William</i>		14. MOTHER'S MARRIED NAME <i>Lena N. Hall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Address same as above</i>	
17. INFORMANT <i>Husband - Leonard Crymes</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Coronary Insufficiency</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4201</i> (b) <i>Advanced coronary arteriosclerosis</i> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Thrombosis, right femoral artery; Thrombo-endo-arterectomy, 5hrs post-surg.</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 5, 1966, to DEC 18, 1967, that (I) (we) last saw the deceased alive on DEC 18, 1967, and that death occurred at 10:30 AM from causes and on the date stated above.		22b. DATE SIGNED <i>DEC 18, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Thomas F. O'Connor</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>8218 Wisconsin Ave. Bethesda, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-21-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL GEM. <i>Cedar Hill Gem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS <i></i>	25a. REC'D BY REGISTRAR DATE <i>DEC 26 1967</i>
		25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH  
12-29-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17189

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17187

1. PLACE OF DEATH a. COUNTY <b>MONT.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>WASHINGTON D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>(3) 3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN &amp; Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KENNETH</b>		First <b>WILLIAM</b>	Middle <b>Cummings</b>
4. DATE OF DEATH <b>12 16 67</b>		Month Year	Day Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-1903</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (State or foreign country) <b>VA.</b>
13. FATHER'S NAME <b>WALTER Cummings</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA CORNELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>223-18-4833</b>	17. INFORMANT Address <b>HOSPITAL Record</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO (b) <b>Acute myocardial infarction;</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Coronary artery heart disease</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Belden R. Reaps</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>BELDEN R. REAPS M.D.</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, county) <b>1410 Belair Rd., Baltimore, Md.</b> DEC. 16, 1967			
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 19, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>St James Episcopal Cemetery, All. Md.</b>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>Hutchinson Funeral Home Owings Mills</b>		24a. ADDRESS <b>11000 Old Columbia Rd., Owings Mills, Md.</b>	24b. REC'D BY REGISTRAR DATE <b>DEC 20 1967</b>
		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

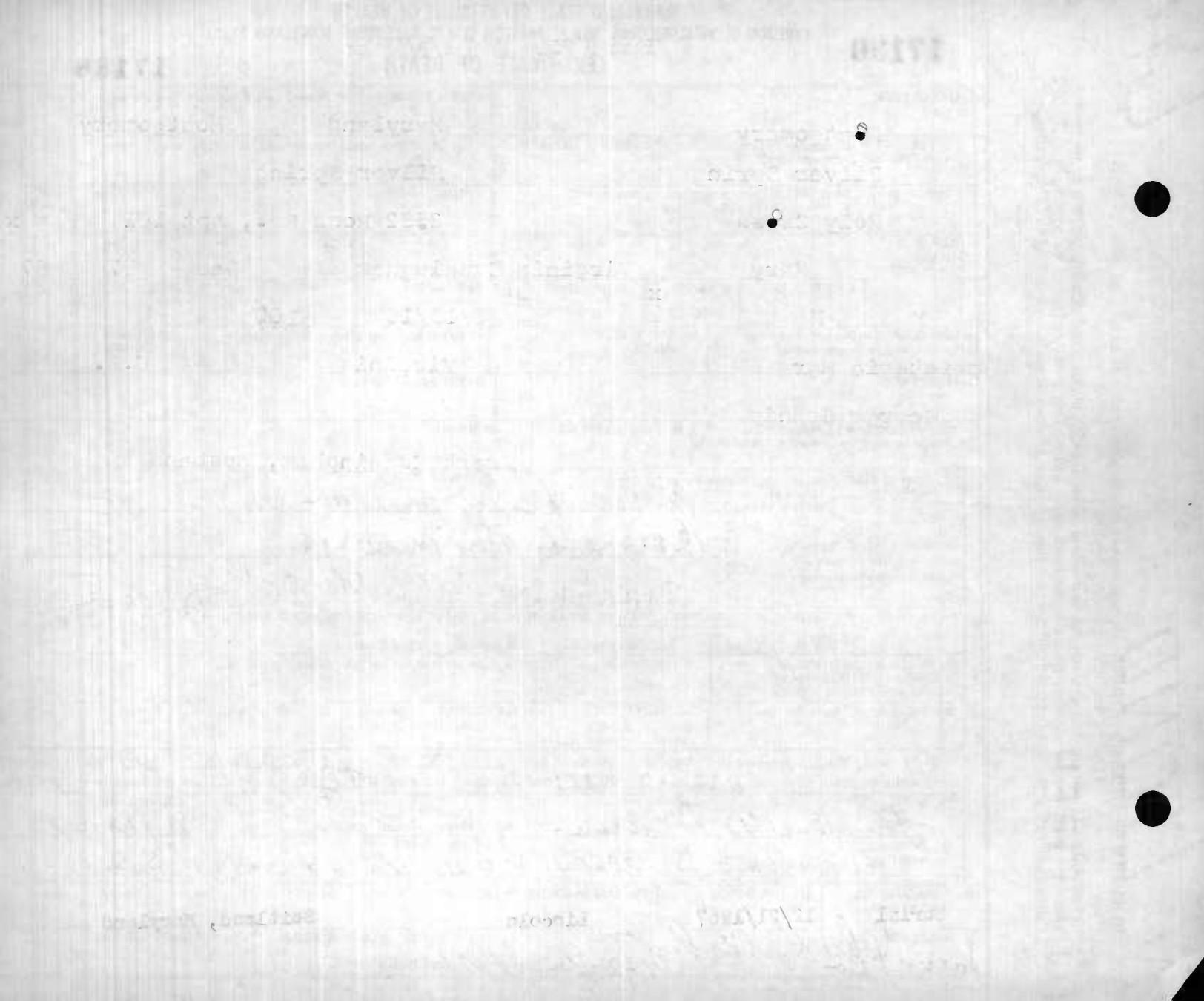
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper pages 2 and 3. Within 72 hours of death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 Film G396 1/2/68 kk

**CERTIFICATE OF DEATH**

17188

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross</b>			d. STREET ADDRESS <b>2532 ROSS Rd., Apt 101</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First	Middle	Last	4. DATE OF DEATH <b>Dec 17 1967</b>	Month Day Year
s. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/16</b>	9. AGE (In years lost birthday) <b>51 60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cafeteria mgr</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>George Gennis</b>			14. MOTHER'S MAIDEN NAME <b>Frank Cunningham, husband</b>			Address
15. WAS DECEASED EVER IN U.S. ARMEO FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Hypertensive Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Suitland</b> (County) <b>Maryland</b> (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <b>63</b> , to _____, 12/17, 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>12/17 1967</b> and that death occurred at <b>902</b> M, from causes and on the date stated above.						
22a. SIGNATURE <b>Lawrence D. Marcus</b>			M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/18/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE D. MARCUS, M.D.</b>			22d. ADDRESS <b>1111 SPRING STREET, S.S.M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/21/1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR <b>Jerry R. Lischer</b>		ADDRESS <b>Farmer's Co 432 - You St N.W.</b>	25a. REC'D BY REGISTRAR <b>MFC 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

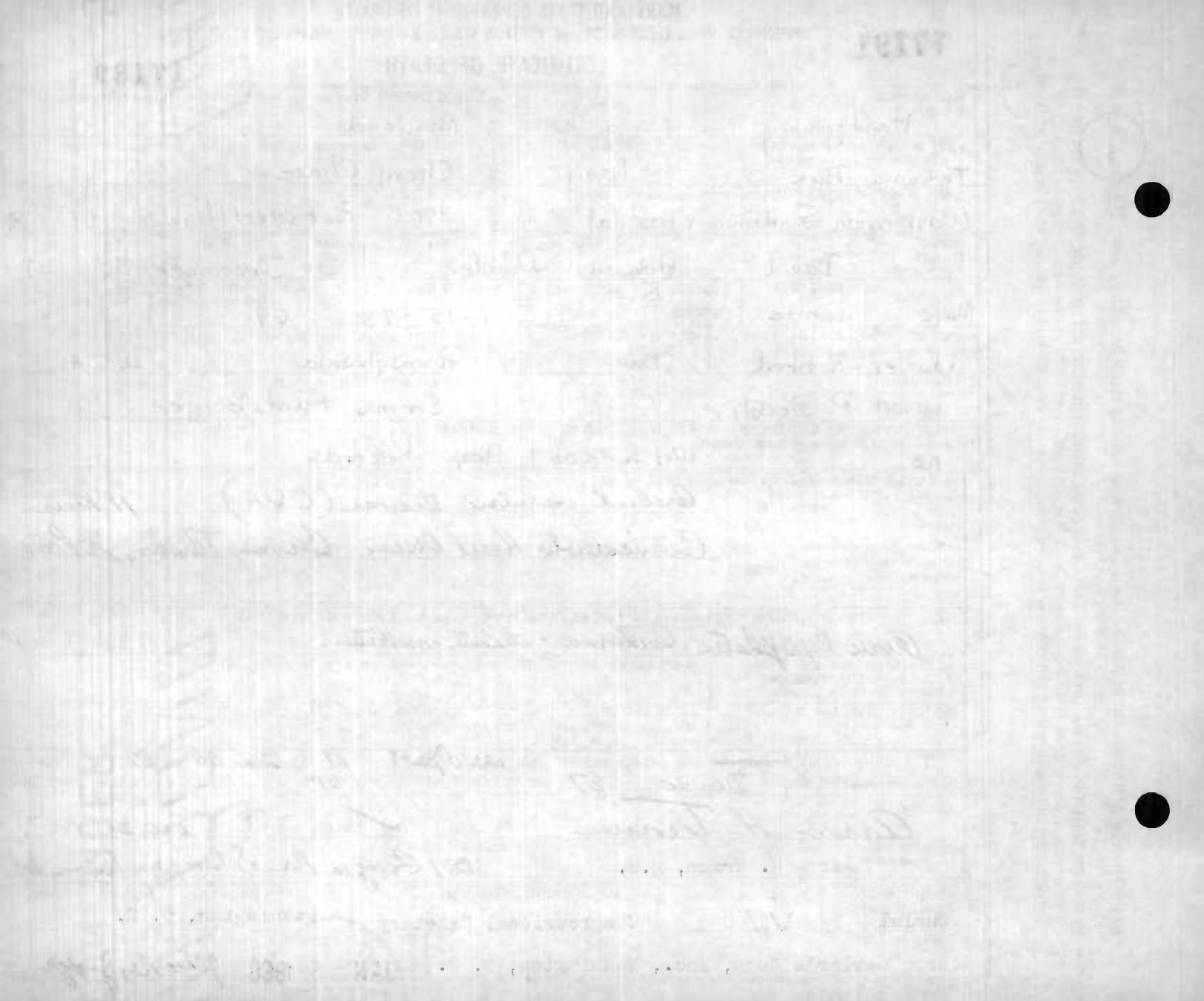
CERTIFICATE OF DEATH

17189

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>MONT</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		d. STREET ADDRESS <b>3708 East West Highway</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium + Hospital</b>				d. STREET ADDRESS <b>3708 East West Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>David Hobson Deibler</b>		First	Middle	Last	4. DATE OF DEATH <b>December 30 1967</b>	Month	Day	Year		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-15-98</b>	9. AGE (In years last birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>lawyer - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>David P. Deibler</b>				14. MOTHER'S MAIDEN NAME <b>Emma Huntzberger</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-36-9900</b>		17. INFORMANT <b>Hosp Records</b>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular disease (CVA)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hours</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerotic Heart Disease - Coronary Thrombosis</b>										
(c) DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Aortic lymphatic embolism - diabetes mellitus.</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>12/30/67</b> , 1967, to <b>Dec 30</b> , 1967, that (I) (we) last saw the deceased alive on <b>Dec 30</b> , 1967, and that death occurred at <b>1:40 PM</b> , from causes and on the date stated above.										
22a. SIGNATURE <b>Aaron H. Traum</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec 30, 1967</b>						
22c. PHYSICIAN'S NAME (Type) <b>Aaron H. Traum, M.D.</b>		22d. ADDRESS <b>8237 Georgia Ave Silver Spring Montgomery Md</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/3/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Congressional Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>				
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., Washington, D. C.</b>		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
				DATE <b>JAN 5 1968</b>						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>19 Days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>			e. STREET ADDRESS <b>11 Starboard Green</b>		
3. NAME OF DECEASED (Type or print) <b>Mariano</b>			First <b>Mariano</b>	Middle <b>Delmundo</b>	Last <b>December 31 1967</b>
4. DATE OF DEATH <b>December 31 1967</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Malayan</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1924</b>	9. AGE (In years last birthday) <b>43 yrs.</b>	IF UNDER 1 YEAR Months <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Imus Cauite, P.I.</b>	
13. FATHER'S NAME <b>Petronilo Delmundo</b>			14. MOTHER'S MAIDEN NAME <b>Antonia Samson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1946-1967</b>		17. INFORMANT <b>11 STARBOARD GREEN Mrs. Basilia Delmundo S.W. Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5411 Duodenal Ulcer with Perforation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO last. (c) _____					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 12 1967</b> to <b>Dec 31 1967</b> that (we) last saw the deceased alive on <b>Dec. 31 1967</b> , and that death occurred at <b>7:00PM</b> , from causes and on the date stated above.					
22c. PHYSICIAN'S NAME (Type) <b>W.R. HIX, M.D.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Jan 1, 1968</b>	
22d. ADDRESS <b>Naval Hospital Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/5/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	
24. FUNERAL DIRECTOR <b>Falls Church Funeral Home, Falls Church, Va.</b>			ADDRESS 25a. REC'D BY REGISTRAR <b>JAN 8 1968</b> 25b. REGISTRAR'S SIGNATURE <b>Charles J. George</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

17193		17191			
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington D.C.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Theodore North Denslow</i>		First	Middle		
4. DATE OF DEATH <i>DEC. 24 1967</i>		Lost	SR.		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>7/4/82</i>		9. AGE (In years last birthday) <i>85 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>(RETIRED) Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Public Schools</i>			
11. BIRTHPLACE (County & State, or foreign country) <i>VERMONT</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>HERBERT M. DENSLOW</i>		14. MOTHER'S MAIDEN NAME <i>ANNA M. OLMSDORF</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>			
17. INFORMANT <i>Josephine Denslow - 3412 Quesada St NW</i>		Address <i>WASH D.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>several days</i>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO <i>491X</i>		(b) _____ DUE TO _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), _____ last. _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Cardiovascular Disease</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <i>Colmar Manor, Silver Spring Md.</i>		(County) <i>Maryland</i>		(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>OCTOBER 1, 1967</i> , to <i>12/24, 1967</i> , that (I) (we) last saw the deceased alive on <i>12/23, 1967</i> , and that death occurred at <i>Colmar Manor, Silver Spring Md.</i> from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <i>G. Leonard Gold</i>		22b. DATE SIGNED <i>12/24/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>G. Leonard Gold, M.D.</i>		22d. ADDRESS <i>8641 Colesville Road, Silver Spring Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>12/26/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>F. Lincoln Cemetery</i>	
23d. LOCATION (City or Town) <i>Colmar Manor, Silver Spring Md.</i>		(County) <i>Maryland</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>H. H. CHAMBERS Co.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 29 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
MARGARET EDITH DONNELLY				Dec. 27 1967	8:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
WHEATON	UNIVERSITY NURSING Home			Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	12b. KIND OF BUSINESS OR INDUSTRY
MD	MONTGOMERY	SILVER SPRING	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	407 MANSFIELD RD	OWN HOME
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	16. ADDRESS
JULIUS FREDERICK WALTERS				JULIA CHRISTINA-SCHMEL	407 Mansfield Place George Donnelly Silver Spring, Md.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No	219-54-9858	George Donnelly			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4221 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) General Debility stating the underlying cause lost. (c) Acute.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Malnutrition					
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Dec. 24, 1967, to Dec. 27, 1967, that (I) (we) last saw the deceased alive on Dec. 24, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Russell C. Bufalino MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED Dec. 27, 1967					
22d. PHYSICIAN'S NAME (Type) Russell C. Bufalino, MD ADDRESS 1429 University Blvd. W. SS. Ind.					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Jan. 2, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Westminster Cemetery	23d. LOCATION (City or Town) Balwynnd Pennsylania	(County)	(State)
24. FUNERAL DIRECTOR John B. Thomas & Sons, Inc.	ADDRESS 8434 Georgia Ave. Silver Spring, Md.	25a. REC'D BY REGISTRAR DATE JAN 8 1968	25b. REGISTRAR'S SIGNATURE Charles J. Judge		

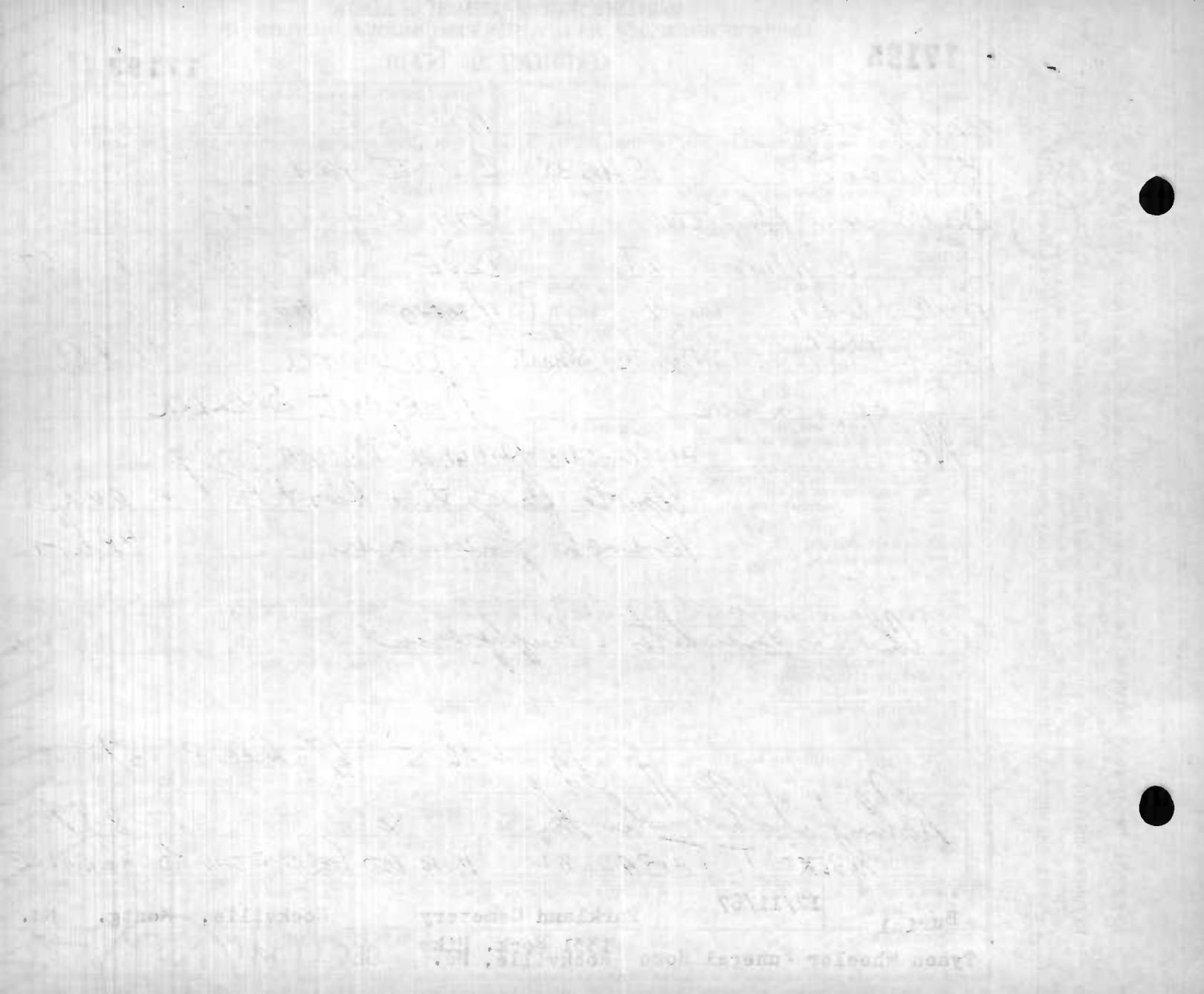
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 and 2, which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with the funeral director.

CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barrett Park</i>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <i>William</i>	Middle <i>J.</i>	Lost <i>Dove</i>	4. DATE OF DEATH Month <i>Dec.</i> Day <i>8</i> Year <i>1967</i>	IF UNDER 1 YEAR Months Days Hours Min. <i>10 8</i>									
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/30/90</i>	9. AGE (In years lost birthday) yrs. <i>77</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Paint-Patch Custodian</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Joseph Dove</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Shepper</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>								16. SOCIAL SECURITY NO. <i>212-12-5813</i>		17. INFORMANT Address <i>Daughter - Margaret Dove</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO <i>Acute congestive heart failure</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Pneumonia</i> <i>29 days</i> (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Chronic bronchitis - Emphysema</i>		21. I certify that (I) (this hospital) attended the deceased from <i>Dec 5, 1967</i> to <i>Dec 8, 1967</i> that (I) (we) last saw the deceased alive on <i>Dec 7, 1967</i> , and that death occurred at <i>11:00 AM</i> , from causes and on the date stated above.											
22a. SIGNATURE <i>Robert T. Thibadeau</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		22b. DATE SIGNED <i>12-8-67</i>							
22c. PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBADEAU</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>		22d. ADDRESS <i>11,000 Old Georgetown Rd Rockville</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/11/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parkland Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 11 1967</i>							
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>1351 Rock Pike Rockville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>please judge</i>											

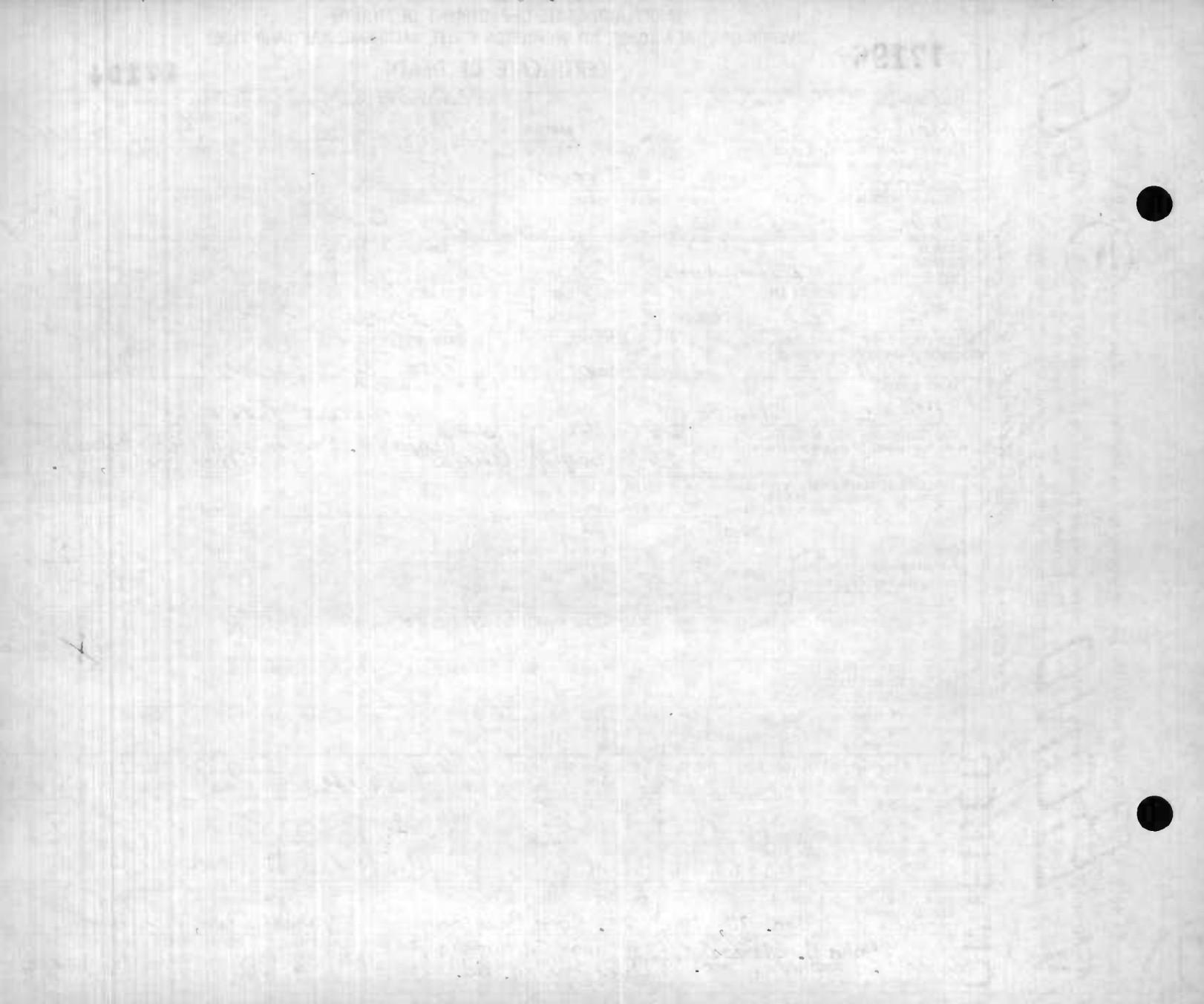


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 director, page 3 should be detached with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH													
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY <u>MONTGOMERY</u>						b. STATE <u>MARYLAND</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>						c. LENGTH OF STAY IN 1b <u>2 weeks</u>							
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>						d. STREET ADDRESS <u>600 Gist Ave.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. &amp; HOSP.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First <u>ELIZABETH</u>	Middle <u>GRACE</u>	Last <u>DOWNEY</u>	4. DATE OF DEATH <u>DEC. 28 1967</u>			Month <u>DEC.</u>	Doy <u>28</u>	Year <u>1967</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <u>9-27-82</u>		9. AGE (In years lost birthday) <u>85 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.S.W.F.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>DIST. OF COLUMBIA</u>					
13. FATHER'S NAME <u>CHARLES Voss</u>						14. MOTHER'S MAIDEN NAME <u>ERLINE RYDER</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>						16. SOCIAL SECURITY NO. <u>219-52-5444</u>							
17. INFORMANT <u>Mrs. Regina G. Downey</u>						Address <u>600 Gist Avenue, Silver Spring, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Fractures</u> 492X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <u>Fractured arm</u> (c) <u>Fractured leg</u>						INTERVAL BETWEEN ONSET AND DEATH <u>yr 2 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
						19							
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , to <u>12/28/67</u> , that (I) (we) last saw the deceased alive on <u>12/27/1967</u> , and that death occurred at <u>720 M</u> , fram causes and an the date stated above.													
22a. SIGNATURE <u>Chas. H. Wilson</u>		M.D. ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/28/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Chas. H. Wilson</u>		22d. ADDRESS <u>740 1/2 Blue Rd NW Wash DC</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 30, 1967</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>St. John Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Forest Glen, Maryland</u>							
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							
VR A15 (4) 25M 1/67													



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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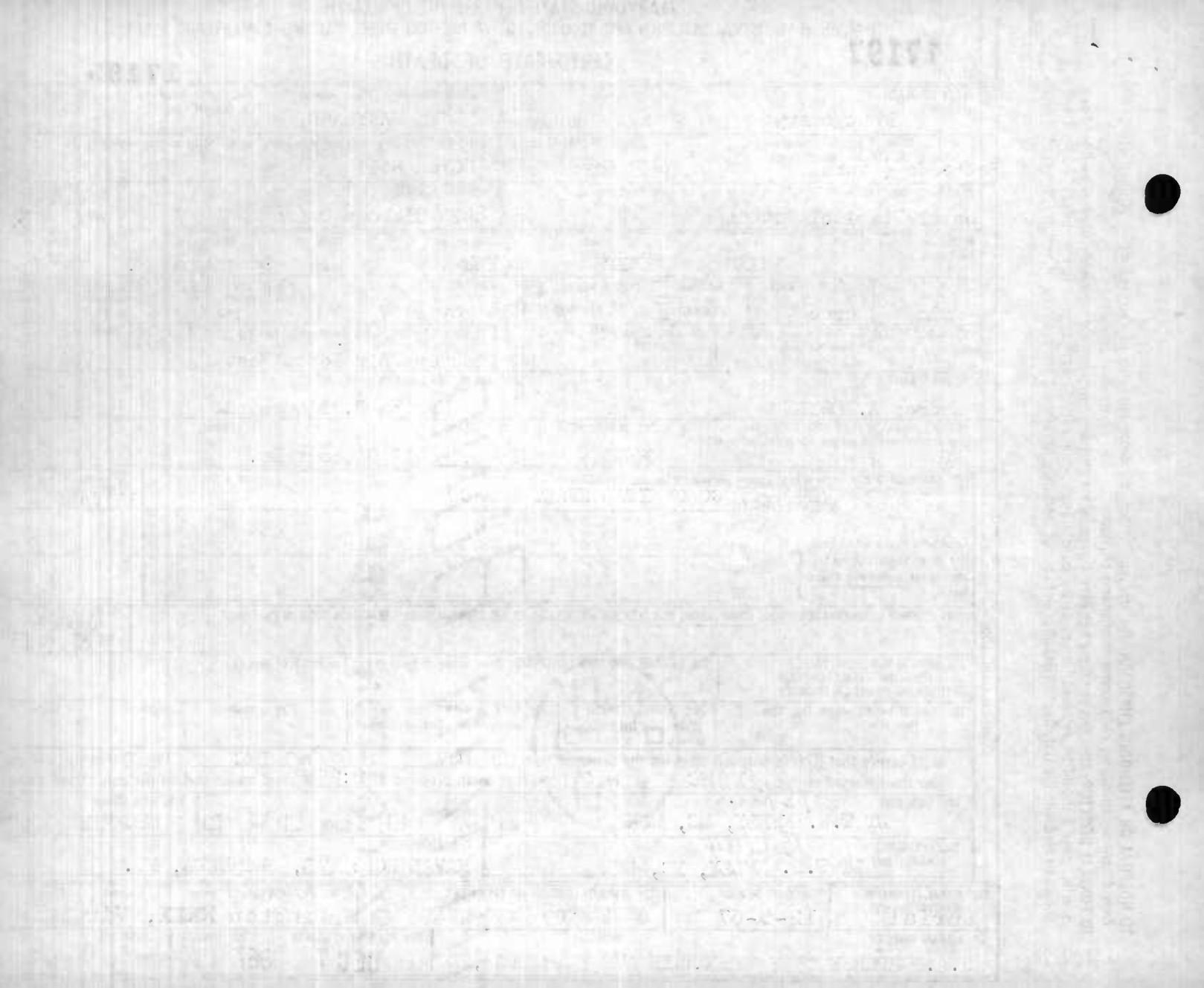
## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital Bethesda</b>				d. STREET ADDRESS <b>8413 Gibbons Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>BRIAN</b>	Middle <b>KEITH</b>	Last <b>DOYLE</b>	4. DATE OF DEATH <b>December 1 1967</b>	Month <b>December</b>	Day <b>1</b>	Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Nov 1967</b>	9. AGE (In years last birthday) yrs. <b>0</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>14</b>	Hours <b>16</b>	Min. <b>30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Andrews Air Force Base</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas A. DOYLE</b>				14. MOTHER'S MAIDEN NAME <b>Martha B. Blanchard</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT		Address <b>Father 8413 Gibbons Dr.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGENITAL HEART DEFECT</b> 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ stated. DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>28 NOV 1967</b> , to <b>1 DEC 1967</b> , that (I) (we) last saw the deceased alive on <b>1 DEC 1967</b> , and that death occurred on <b>2:25 PM</b> from causes ond on the date stated above.										
22a. SIGNATURE <i>T.E. Kelly</i>		LT T.E. KELLY, MC, USN		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>3 DECEMBER 1967</b>			
22c. PHYSICIAN'S NAME (Type) <i>T.E. Kelly</i>		LT T.E. KELLY, MC, USN		22d. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-5-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington XXXX, Virginia</b>				
24. FUNERAL DIRECTOR <b>R.A. PUMPHREY 7557 WISCONSIN AVE BETHESDA, MD</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 7 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17198

## CERTIFICATE OF DEATH

17196

## 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Chevy Chase

c. LENGTH OF STAY IN 1B

weeks

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3204 Parkview Road

3. NAME OF DECEASED  
(Type or print)First  
NORA

Middle

Last  
DUFFY4. DATE  
OF  
DEATHMonth Dec. 5, 1967  
Day  
Year

## 5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Apr. 10, 1884

9. AGE (In years  
last birthday)

83

IF UNDER 1 YEAR

yrs.

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County &amp; State, or foreign country)

Ireland

12. CITIZEN OF WHAT COUNTRY?

U. S.

## 13. FATHER'S NAME

Patrick Ryan

## 14. MOTHER'S MAIDEN NAME

Mary Walsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or date of service

No

16. SOCIAL SECURITY NO.

142-38-3130

## 17. INFORMANT

Daughter  
Mrs. Stephen Timko

Address

Same as Item 2.

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

332X

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

DUE TO

(c)

Cerebral Thrombosis  
arteriosclerosisINTERVAL BETWEEN  
ONSET AND DEATH  
2 days

?

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 1920d. INJURY OCCURRED  
While  Not While   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from ..... 7th to 5 Dec., 1967 that (I) (we) last  
saw the deceased alive on ..... 3 Dec. 1967, and that death occurred at ..... 15A.M. from the causes and on the date stated above.

## 22a. SIGNATURE

William D. Aud

M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.22c. PHYSICIAN'S  
NAME (Type)

WILLIAM D. AUD

22b. DATE  
SIGNED23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

23b. DATE THEREOF

12-9-67

23c. NAME OF CEMETERY OR CREMATORI

St. Mary's Cemetery

23d. LOCATION (City, town or county)

(State)

Trenton, New Jersey

## 24 FUNERAL DIRECTOR'S SIGNATURE

ROBERT A. PUMPHREY, Bethesda, Maryland

## ADDRESS

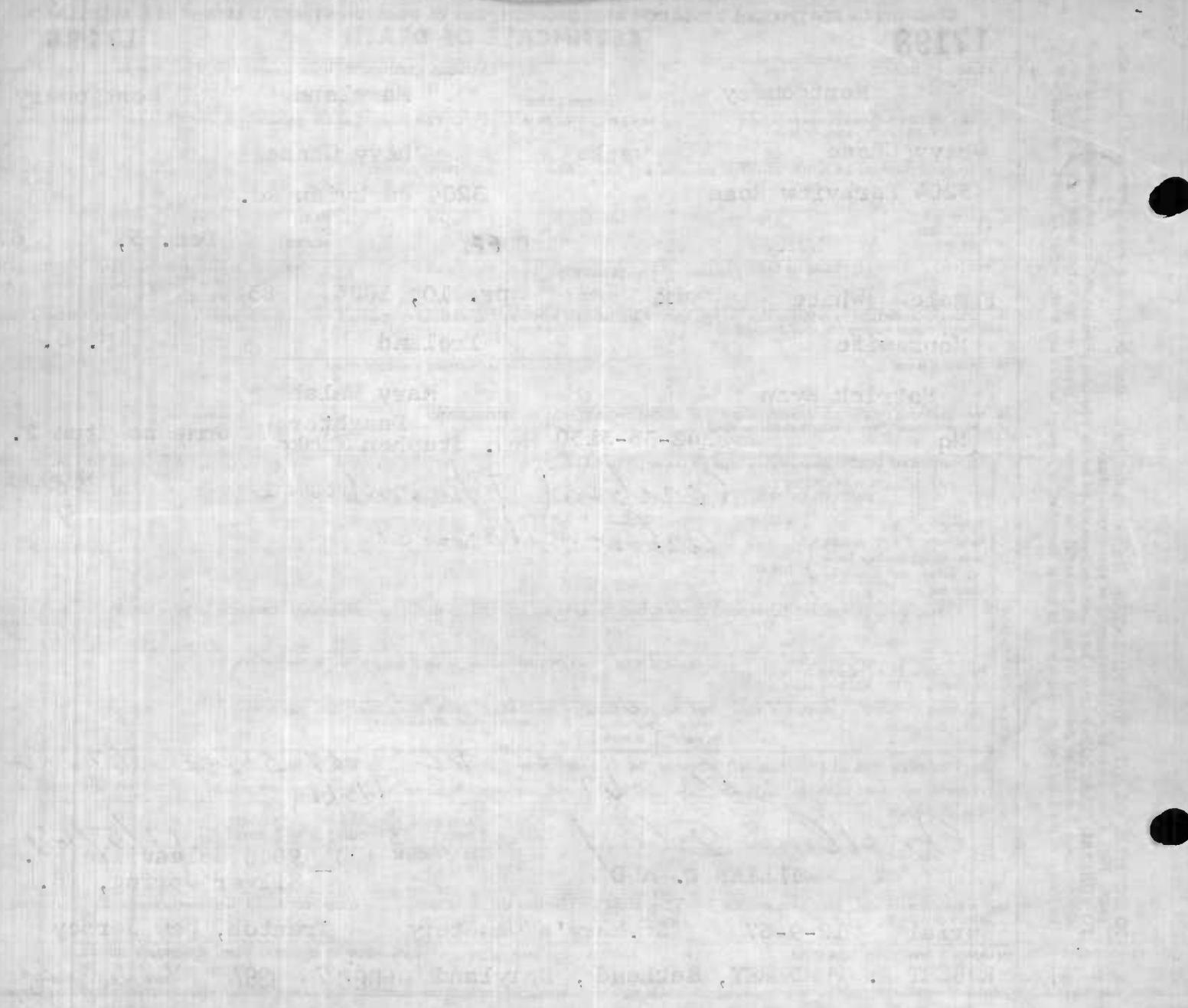
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE DEC 7 1967

Charles Judge

8011



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

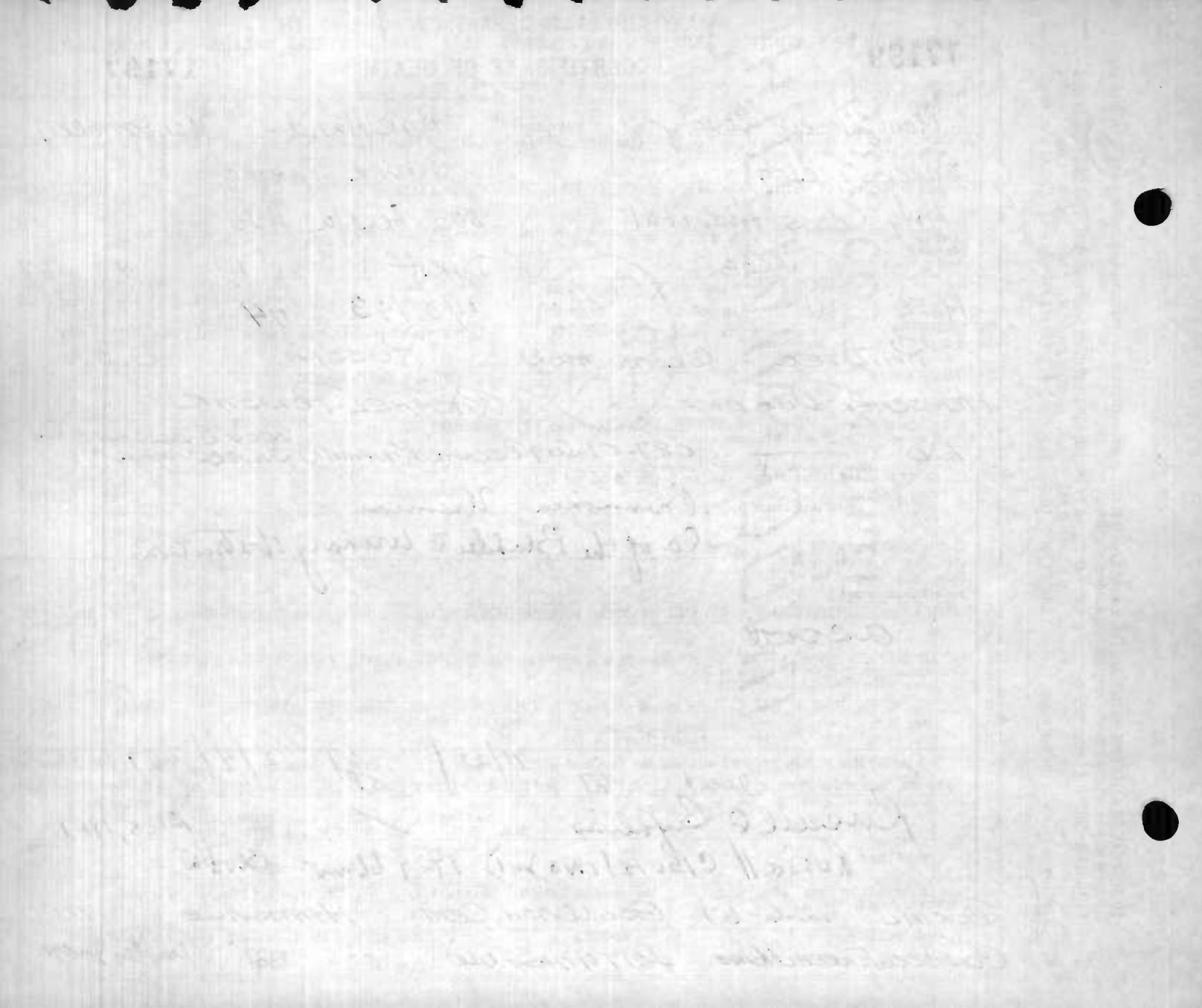
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17197

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	d. STREET ADDRESS <i>805 Acola Ave.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>JACOB</i>	First <i>JACOB</i>	Middle <i></i>	Last <i>Dukoff</i>	4. DATE OF DEATH <i>12/4/67</i>	Month <i>12</i>	Day <i>4</i>	Year <i>1967</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/2/93</i>	9. AGE (In years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Herzschel Dukoff</i>	14. MOTHER'S MAIDEN NAME <i>PACHAEL POLISAR</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>087-01-5007</i>	17. INFORMANT <i>Bernard Korman</i>	Address <i>1009 N. Belvedere Rd Silver Spring, MD</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1810</i>				<i>Pneumonia, Ureria</i>				
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				DUE TO (b) <i></i>	<i>Ca of the Bladder &amp; Urinary obstruction</i>			
DUE TO (c) <i></i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ascvcl</i>								
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>11/23/67</i> to <i>12/4/67</i> , 1967, that (I) (we) last saw the deceased alive on <i>Dec 4, 1967</i> , and that death occurred at <i>SP</i> M, from the causes and on the date stated above.				22b. DATE SIGNED <i>Dec 5, 1967</i>				
22a. SIGNATURE <i>Russell G. Bufalino</i>				22b. ADDRESS <i>1929 Univ. Blvd.</i>				
22c. PHYSICIAN'S NAME (Type) <i>Russell G. Bufalino, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	M.D. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>12-6-67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>GEO. L. VASH, Cem.</i>	23d. LOCATION (City, town or county) <i>HYATTSVILLE</i>	(State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>Conococheague Home</i>				ADDRESS <i>42179 Hwy 50. W.</i>	25a. REC'D BY REGISTRAR <i>DEC 8 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
				DATE				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17200

CERTIFICATE OF DEATH

17198

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>		d. STREET ADDRESS <b>6928 Ruskin Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gary</b>		First <b>Eugene</b>	Middle <b>Dunaway</b>
4. DATE OF DEATH <b>December 31, 1967</b>	Month <b>December</b>	Doy <b>7</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> <b>Divorced <input type="checkbox"/></b>	NEVER MARRIED <input checked="" type="checkbox"/>
8. B. DATE OF BIRTH <b>31 March 1961</b>		9. AGE (In years lost birthday) <b>6 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter J. Dunaway</b>		14. MOTHER'S MAIDEN NAME <b>Christine Saunders</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hypoxia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
2893 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b>		3 Weeks	
2893 (c) <b>Cystic Fibrosis of the Pancreas</b>		6 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 22, 1967</b> , to <b>Dec. 7, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 7, 1967</b> , and that death occurred at <b>6:18 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Stuart Handwerger</b>		P. M. M.D. ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>12/8/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Stuart Handwerger, M. D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE THEREOF <b>12/10/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Falling River Church</b>
24. FUNERAL DIRECTOR <b>Charles J. Hinman</b>		ADDRESS <b>Brookneal, Va.</b>	25a. LOCATION (City or Town) (County) (State) <b>Brookneal Campbell Va.</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

00531

100

100

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17201

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17199

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Van Eck</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>6015 Massachusetts Ave.</i>		d. STREET ADDRESS <i>6015 Massachusetts</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Naomi</i>	First <i>S.</i>	Middle <i>Dunman.</i>	4. DATE OF DEATH <i>Dec. 24, 1967</i>			
5. SEX <i>f-</i>	6. COLOR OR RACE <i>w.</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>Oct 11, 1888</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Arkansas.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William Jennings</i>	14. MOTHER'S MAIDEN NAME <i>Dora Green</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>578 68 9820</i>	17. INFORMANT <i>Olin E Teague Daughter</i>	Address <i>same above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause _____ last. (c) _____						
CORONARY INSUFFICIENCY. ACUTE. INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	22. DATE SIGNED <i>12/24/67.</i>	
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	Address (Street, city, town, or county) <i>Bethesda, Md.</i>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>	23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-29-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Olivet</i>	23d. LOCATION (City or Town) <i>Fort Worth</i> (County) <i>Texas</i> (State) <i></i>		
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>	ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>	25a. REC'D BY REGISTRAR <i>DEC 29 1967</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
VR A15ME (5) 6M 1/67		DATE				

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17200

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) Thomas A. Dunnington			First	Middle	Lost	20. DATE OF DEATH Month Dec Doy 30, Year 1967	2b. HOUR 3 <sup>rd</sup> P.M.
3. SEX Male	4. RACE White	S. DATE OF BIRTH 5-3-16	6. AGE (In years lost birthday) 51 YRS.			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10419 Lorain Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Government		12b. KIND OF BUSINESS OR INDUSTRY Contract	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Montgomery	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 10419 Lorain Ave.		151	
14. FATHER'S NAME G. Howard Dunnington	First	Middle	Lost	15. MOTHER'S MAIDEN NAME Mary H. Miller	First	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16b. SOCIAL SECURITY NO. WWII 577-05-1176		17. INFORMANT Mrs. Frances F. Dunnington		Address #13e Same as	
PART 1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> IMMEDIATE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Mon Doy Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>67</u> , to <u>12/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. F. Thibadeau MD</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) A. F. THIBADEAU		22e. ADDRESS 10111 Colesville Rd. SIL. SP. MD.					
23a. BURIAL, CREMATION, BURIAL (Specify)	23b. DATE 1-3-68	23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHN'S CEMETERY	23d. LOCATION (City or Town) FOREST GLEN, MONT. MD.		(County) (State)		
24. FUNERAL DIRECTOR FRANCIS J. COLLINS	ADDRESS 3821 14th ST. N.W.	ADDRESS WASH. D.C.	25a. REC'D. BY REGISTRAR JAN 5 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

6037

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17203

CERTIFICATE OF DEATH

17201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb. <i>1 HR 50 MIN</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		d. STREET ADDRESS <i>Kensington Gardens Nurs. Home</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Sally</i>		First <i>Sally</i>	Middle <i>MAY</i>	Lost <i>Eaton</i>	4. DATE OF DEATH Month <i>Dec</i>	Doy <i>23</i>	Year <i>1967</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-11-1878</i>	9. AGE (In years less birthday) yrs. <i>89</i>	IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Co Maryland Frederick</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Samuel Webster</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Palmer</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-5402-820</i>		17. INFORMANT <i>Son - Ralph Eaton, 2221 Beverly Dr.</i>		Address <i>Laguna Woods</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i>		DUE TO <i>acute pulmonary edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASC v3</i>		DUE TO (c) <i>Diabetes mellitus</i>				yes yes		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>dec 1</i> , 1967, to <i>dec 23</i> , 1967, that (I) (we) last saw the deceased alive on <i>23 Dec 1967</i> , and that death occurred at <i>600 M</i> , from causes and on the date stated above.								
22a. SIGNATURE <i>Horace W. Bender, M.D.</i>		22b. DATE SIGNED <i>12/23/67</i>						
22c. PHYSICIAN'S NAME (Type) <i>Dr. Fred W. Gifford</i>		22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-26-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Faith United Ch of Christ Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Charlesville, Md.</i>		
24. FUNERAL DIRECTOR <i>Raymond E. Creaghead</i>		ADDRESS <i>Croaghead Funeral Home, Thurmont, Md.</i>		25a. REC'D. BY REGISTRAR DATE <i>DEC 27 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>		

60551

60551



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17204		17202	
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN lb <i>DoP</i>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
<b>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</b> <i>Suburban Hospital</i>		<b>d. STREET ADDRESS</b> <i>11409 Newport Mill Rd</i>	
<b>3. NAME OF DECEASED</b> First <i>Male</i> Middle <i>E.</i> Last <i>Ebner</i> (Type or print)		<b>4. DATE OF DEATH</b> Month <i>Dec</i> Day <i>6</i> Year <i>1967</i>	
<b>5. SEX</b> <i>F</i> <b>6. COLOR OR RACE</b> <i>W</i>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <i>9/8/1895</i>		<b>9. AGE (In years last birthday)</b> <i>72 yrs.</i>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <i>Retired Statistical Clerk</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Agriculture</i>	
<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <i>Nebraska</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>Samuel K. Longacre</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Elizabeth Shook</i>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</b> <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>578-46-5671-B</i>	
<b>17. INFORMANT</b> <i>Roy A. Ebner</i>		<b>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO <i>416X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic heart disease</i> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> 60 year	
<b>19. WAS AUTOPSY PERFORMED? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>)</b>			
<b>20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>			
<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <i>Hour a.m.</i> p.m. <i>p.m.</i> 19		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>None</i>		<b>20f. (City or town) (County) (State)</b> <i>(None)</i>	
<b>21. I certify that (I) (this hospital) attended the deceased from <i>Nov 16</i>, 1967, to <i>Dec 12/67</i>, 1967, that (I) (we) last saw the deceased alive on <i>August 4</i>, 1967, and that death occurred at <i>Suburban Hospital</i>, from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <i>Carl P. Segal</i>		<b>22b. DATE SIGNED</b> <i>12/6/67</i>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <i>Jack P. Segal</i>		<b>22d. ADDRESS</b> <i>5323 Conn Ave NW Washington DC</i>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>Dec 9, 1967</i>	
<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <i>Parklawn Cemetery</i>		<b>23d. LOCATION (City or Town) (County) (State)</b> <i>Rockville, Maryland</i>	
<b>24a. FUNERAL DIRECTOR</b> <i>C. Glen Carter</i> <i>Warren E. Pumphrey, Inc.</i>		<b>24b. ADDRESS</b> <i>8434 Georgia Avenue Silver Spring, Md.</i>	
		<b>25a. REC'D BY REGISTRAR</b> <i>Dec 11 1967</i>	
		<b>25b. REGISTRAR'S SIGNATURE</b> <i>James C. Glenn</i>	

8087.

Marine Sciences

8087



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

17205

**CERTIFICATE OF DEATH**

17203

**1. PLACE OF DEATH**

a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring 16 yrs

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

10611 Lockridge Drive

**3. NAME OF DECEASED**  
(Type or print)

First Susan Middle Tilton Last Ellis

**2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)**

a. STATE

Md.

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

10611 Lockridge Drive

e. IS RESIDENCE ON A FARM?

YES  NO

**5. SEX**

F

**6. COLOR OR RACE**

W

**7. MARRIED**

NEVER MARRIED

WIDOWED

DIVORCED

**8. DATE OF BIRTH**

June 6-1906

**9. AGE (In years last birthday)**

67 yrs.

**10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)**

Sales clerk

**10b. KIND OF BUSINESS OR INDUSTRY**

Retail

**11. BIRTHPLACE (County & State, or foreign country)**

Dayton, Ohio

**12. CITIZEN OF WHAT COUNTRY?**

U.S.

**13. FATHER'S NAME**

John W. Tilton

**14. MOTHER'S MAIDEN NAME**

Mary Belle Marr

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)**

NO

**16. SOCIAL SECURITY NO.**

579 48 4812

**17. INFORMANT**

Warren Ellis - Same

Address

**MEDICAL CERTIFICATION**

**20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)**

**20c. TIME OF INJURY** Month, Day, Year  
Hour a.m.      p.m.  
19

**20d. INJURY OCCURRED**  
While  Not While   
at work  at work

**20e. PLACE OF INJURY (Home, farm, factory, straat, officia bldg., etc.)**

**20f. (City or town)**

**(County)**

**(State)**

**21. I certify that (I) (this hospital) attended the deceased from Oct 19, 1966, to Dec 15, 1967, that (I) ( ) last saw the deceased alive on Dec 11, 1967, and that death occurred at 7 A.M. from the causes and on the date stated above.**

**22a. SIGNATURE**

James W. Egan

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

**22b. DATE SIGNED**

December 15, 1967

**22c. PHYSICIAN'S NAME (Type)**

James W. Egan

**22d. ADDRESS**

5413 Cedar Lane - Bethesda

**23a. BURIAL, CREMATION, REMOVAL (Specify)**

Burial Dec. 18, 1967 Arlington National

**23b. DATE THEREOF**

Arlington

**(State)**

Virginia

**23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS**

C. Carter

8434 Georgia Ave. S.S.

**23d. LOCATION (City, town or county)**

Charles Judge

**(State)**

**24. FUNERAL DIRECTOR'S SIGNATURE**

C. Carter Warner E. Pumphrey Inc. 8434 Georgia Ave. S.S. DEC 21 1967

12052

MEDICAL EXAMINER  
NOTIFIED WILL APPROVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17206

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17204

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
SIMMA		-	ELVOVE	Month 12 Day 31 Year 1967	8 P.M.
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	
FEMALE	CAUS.	10/20/1879	88 YRS.	MONTHS	IF UNDER 24 HRS.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	DAYS HOURS MIN.	
RUSSIA	U.S.A.		MONTGOMERY		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working-life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
NHEATON Md.	HOMEC UNIVERSITY NURSING	HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased admission) STATE	lived, if institution: Residence before 13b. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
DC	D.C. ✓ NW. Wash		4725 8 <sup>th</sup> ST. N.W.		
14. FATHER'S NAME	First	Middle	15. MOTHER'S MAIDEN NAME	First	Middle
SOHOMON		- ELVOVE	BARSHEVA		BARSKY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	Address		
No	599-62-9649	ETHEL ELVOVE - SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Heart Failure</u> immediate 4200 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last) (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <u>Diabetes Mellitus</u>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>10-24-</u> , 19 <u>65</u> , to <u>12-31-</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>11-28</u> 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Samuel A. Hillman MD</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>11/1/68</u>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>8829 FLOWER AVE SILVER SPRING MD 20901</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>1-2-1968</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>GEO WASH Cem. Inc.</u>	23d. LOCATION (City or Town) <u>HYATTSVILLE MD</u>	(County) (State)
24. FUNERAL DIRECTOR		ADDRESS <u>Gooding Funeral Home 4217-9 Lee</u>	25a. REC'D BY REGISTRAR DATE <u>1 AM</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

20SYT

1031

1

**M** 17207  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
Item #2b,c & d Film #G190 12/20/67 ph

**CERTIFICATE OF DEATH**

17205

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
a. COUNTY <b>Montgomery</b> MARYLAND		a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN lb <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b> Havre de Grace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS 709 S. Washington St. <b>ASBURY METHODIST HOME</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELIZABETH T. EVANS</b>		First	Middle
Last		4. DATE OF DEATH <b>December 6 1967</b>	Month Day Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>March 22-1891</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital Dining Services RETIRED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN WESLEY THOMPSON</b>	
14. MOTHER'S MAIDEN NAME <b>ALICE REBECCA WARD</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>212-32-17054</b>		17. INFORMANT <b>MRS AMY BEVAN HAUKE DEGRANGE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Atherosclerotic Heart Disease</b>		IMMEDIATE BETWEEN INJURY AND DEATH 4201 6 mos	
(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>3167</b> (County) <b>12/6/67</b> (State) <b>MD</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>3/67</b> , 19 to <b>12/6/67</b> , 19, thot (I) (we) lost saw the deceased alive on <b>12/6/67</b> , and that death occurred <b>12/6/67</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Henry C. Scruggs MD</b>		22b. DATE SIGNED <b>12/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry C. Scruggs MD</b>		22d. ADDRESS <b>5413 Cedar Lane Bethesda Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>DEC 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ANGEL HILL CEM.</b>
24. FUNERAL DIRECTOR <b>R. Madison Mitchell, Havre de Grace Md</b>		ADDRESS	23d. LOCATION (City or Town) (County) (State) <b>HARVE DE GRACE MD</b>
		25a. REC'D BY REGISTRAR <b>Charles Jones</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>
		DATE <b>DEC 11 1967</b>	

VOSTE

5  
1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17208

CERTIFICATE OF DEATH

17206

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours of her death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney, Md.</b>		c. LENGTH OF STAY IN lb <b>18 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e. STREET ADDRESS <b>Washingtonian Towns Apt 1106</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>RICHARD</b>	Middle <b>WALTER</b>	Last <b>EVANS</b>	4. DATE OF DEATH Month <b>12</b>	Day <b>08</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8/24/29</b>	9. AGE (In years last birthday) yrs. <b>38</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bondsman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>salesman</b>		11. BIRTHPLACE (County & State, or foreign country) <b>California</b>	
13. FATHER'S NAME <b>Richard W. Evans Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Beatrice Whold</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Hospital records</b> <b>Olney, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO <b>Exsanguination, Acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ESOPHAGEAL VARICES</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
(b) DUE TO <b>Cirrhosis, Liver</b>				Months? <b>Months?</b>	
(c) DUE TO <b>Acute Congestive Heart Failure</b>				Months? <b>Months?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Drugs</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drugs</b>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 20, 1967</b> , to <b>Dec. 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 8, 1967</b> , and that death occurred <b>at 12:45 p.m.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Jack Shumacher</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-9-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Jack Shumacher</b>		22d. ADDRESS <b>105 Russell Ave., Gaithersburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-12-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gaithersburg Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Gaithersburg County Md</b>	
24. FUNERAL DIRECTOR Ernest C. Gartner		ADDRESS <b>Brush &amp; Gartner, Gaithersburg, Md.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
			DATE DEC 14 1967		

10551

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Mahoning</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN lb <b>7 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Struthers</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b> 20014						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Mary</b>	Middle <b>Ann</b>	Last <b>Fabek</b>	4. DATE OF DEATH <b>December 3 1967</b>	Month <b>December</b>	Day <b>3</b>	Year <b>1967</b>	IF UNDER 1 YEAR Months <b>10</b>	IF UNDER 24 HRS. Days <b>10</b>	Hours <b>Min.</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>13 August 1957</b>	9. AGE (In years last birthday) <b>10 yrs.</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Thomas J. Fabek</b>						14. MOTHER'S MAIDEN NAME <b>Ann Susany</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Low cardiac output</u> INTERVAL BETWEEN ONSET AND DEATH 2 hours											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>mitral valve replacement, subaortic infundibulotomy 2 days</u> (c) <u>replacement, subaortic stenosis</u> DUE TO Post operative closure atrial septal defect, DUE TO Congenital atrial septal defect, mitral valve 10 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>26 November 1967</b> , to <b>3 December 1967</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>3 December 1967</b> , and that death occurred at <b>7:25 M</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>Rudolf N. Staroscik</b>						M.D.	ATTENDING PHYS.	A.M. MED.	STAFF PHYS.	22b. DATE SIGNED <b>3 December 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rudolf N. Staroscik, M.D.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-6-67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Calvary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Youngstown, Ohio</b>					
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>						ADDRESS	25a. REC'D BY REGISTRAR <b>Charles J. Gandy</b>		25b. REGISTRAR'S SIGNATURE		
						DATE <b>DEC 7 1967</b>					

1931

POST

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17210 17208  
1/17/73 nh CERTIFICATE OF DEATH Montgomery, Md.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE 2617 Blueridgeville. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb 4 yrs - 5 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alfonso,		First	Middle	Last	4. DATE OF DEATH 12 Month 10 Day 1967 Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-1893	9. AGE (In years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Mason Contractor		11. BIRTHPLACE (County & State, or foreign country) Italy	
13. FATHER'S NAME ANTHONY FAGNANI		14. MOTHER'S MAIDEN NAME ROSE UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 068-07-7234		17. INFORMANT Address Pauline Fagnani 2617 Blueridgeville, Wheaton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) <u>Viral</u> DUE TO stating the underlying cause lost. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome 3 1/2 yrs; Diabetes mellitus.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Silver Spring	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1967</u> to <u>Dec. 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec. 10, 1967</u> , and that death occurred at <u>9:40 P.M.</u> from causes and on the date stated above.					
22o. SIGNATURE Bertram F. Schaefer M.D.		22b. DATE SIGNED Dec. 10, 1967			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 1780 Mass. Ave. N.W. Washington, D.C.			
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 13 Dec. 1967	23c. NAME OF CEMETERY OR CREMATORIUM GATE OF HEAVEN Cemetery	23d. LOCATION (City or Town) Silver Spring	(County) (State)
24. FUNERAL DIRECTOR Rinaldi Funeral Home, 3400 Georgia Ave. N.W.		ADDRESS DC 20012	25o. REC'D BY REGISTRAR Date DEC 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

Item # 15 Film G 462 8/17/73 mh

DOCUMENTS ACCEPTED AS SUPPORTING EVIDENCE

1. Discharge cert. from Army  
dated 1919

To change Item # 15  
from no  
to yes

2.

To change \_\_\_\_\_  
from \_\_\_\_\_  
to \_\_\_\_\_

Evidence returned

Aug. 17 19 73 by mh

FOR STATE  
HEALTH DEPT.

1  
necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17211  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
17209

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>1 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 1521				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			d. STREET ADDRESS <b>1714 Dublin Dr.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Stanley</b>	Middle <b>Brooks</b>	Last <b>Fairfax</b>	4. DATE OF DEATH December 19 1967	Month Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/3/09</b>	9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Soldiers Govt. Home</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> W.W. II			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Stepson, John Haas</b>		Address 1714 Dublin Dr. Sil. Spr., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Acute Coronary Insufficiency with fibrillation and Heart Block</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Coronary Artery Heart Disease.</b> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Belden R. Reop, M.D.</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <i>BELDEN R. REOP, M.D.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, county) <i>Denton</i> Dec. 20, 1967								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-23-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash., D.C.</b>		
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home, 7400 Georgia Ave.</b>			ADDRESS <b>Wash., DC</b>			25a. REC'D BY REGISTRAR <b>DEC 26 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>

EST

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.E. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 396  
1-15-68 ams MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17210

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>			b. COUNTY <b>PR. GLO</b>		
c. LENGTH OF STAY IN lb <b>DOA</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; Hosp.</b>			d. STREET ADDRESS <b>8110 TAHONA DR</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>ROBERT</b>	Middle <b>HENRY</b>	Last <b>FALES</b>	4. DATE OF DEATH Month <b>12</b>	Year <b>22 1967</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5-6-46</b>	9. AGE (In years lost birthday) yrs. <b>21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HELPER - SILVER SPRING IRON WKS.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>FRED L FALES</b>		14. MOTHER'S MAIDEN NAME <b>LOLA V. JAMESON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>WM L. FALES, Route 41, HAGERSTOWN, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure due to</b> DUE TO <b>891.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carbon monoxide intoxication</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased overcome by fumes from truck motor running in closed garage</b>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>8:00 AM 12-22 1967</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Garage</b>	20f. (City or town) (County) (State) <b>Silver Spring Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Belden R. Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (if not in town or county)		22. DATE SIGNED <b>DEC. 22, 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec 26, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Md.</b>		
24. FUNERAL DIRECTOR <b>Takoma Funeral Home Inc. Arthur Walter</b>	ADDRESS <b>254 Carroll St.</b>	25a. REC'D BY REGISTRAR <b>Charles J. Jager</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Jager</b>		
DATE <b>DEC 27 1967</b>					
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FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17213

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17211

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium</b>				
3. NAME OF DECEASED (Type or print)		First <b>ANN</b>	Middle <b>(NMN)</b>	Lost <b>FELDMAN</b>	4. DATE OF DEATH <b>12 27 1967</b>	Month Year	Doy Year	
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>7-10-1895</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	Hours Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MD.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>HARRIS SILVERSTEIN</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>577-32-6117</b>	17. INFORMANT <b>MR HERMAN FELDMAN (HUSBAND)</b>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Cardiac Tamponade due to</b> DUE TO (b) <b>Dissecting aneurysm of</b> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (c) <b>ascending Aorta</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Bethesda</b>	(County) <b>Montgomery</b>	(State) <b>MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Belden R. Neap</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>BELDEN R. NEAP M.D. Totowa</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street and County) <b>Dec. 28, 1967</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-29-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Valley Memorial Park</b>	23d. LOCATION (City or Town) <b>Falls Creek</b>	(County) <b>Montgomery</b>	(State) <b>VA.</b>			
24. FUNERAL DIRECTOR <b>Gordon Funeral Home</b>	ADDRESS <b>4217 19th St. N.W.</b>	25a. REC'D BY REGISTRAR DATE <b>JAN 2 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17212

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**10. HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Colonial Villa Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle		4. DATE OF DEATH December 20 1967	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 20, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Men's Furnishinh	
13. FATHER'S NAME Harry Feldman		14. MOTHER'S MAIDEN NAME Rebecca Cohen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Seymour Feldman		Address same as 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A.S.H.D. Acute myocardial infarction</i> <i>4201</i> DUE TO <i>Chronic coronary artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>17 years</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <i>July 1950</i> to <i>12/30 1967</i> , that (I) (we) last saw the deceased alive on <i>12/10 1967</i> , and that death occurred at <i>10:30 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Herbert Wechsler</i>		22b. DATED SIGNED <i>12/20/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Herbert Wechsler</i>		22d. ADDRESS <i>1800 Eye St NW 6th floor</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-22-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>National Memorial Park</i>
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home</i>		23d. LOCATION (City or Town) <i>Falls Church</i> (County) <i>Falls Church</i> (State) <i>Va.</i>	
ADDRESS <i>4217 9th St., N.W.</i>		25a. REC'D BY REGISTRAR <i>DEC 26 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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and I am deeply grateful to H. C. A. M. for his help.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17215

CERTIFICATE OF DEATH

17213

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>PR GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		d. STREET ADDRESS <b>7206 Flower Ave</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANATORIUM</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>MARIA</b>	Middle <b>AMELIA</b>	Lost <b>FERNANDEZ</b>	4. DATE OF DEATH <b>10-17-24</b>	Month <b>12</b>	Doy <b>2</b>	Year <b>1967</b>	
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-17-24</b>	9. AGE (In years last birthday) <b>43 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CUBA</b>		12. CITIZEN OF WHAT COUNTRY? <b>CUBA</b>			
13. FATHER'S NAME <b>Diego Fernandez</b>				14. MOTHER'S MAIDEN NAME <b>Antonina Maria Paz</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>11422 Rockley Ave., Kensington Md.</b> <b>Carlos Sera Brother-in-law</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Pulmonary Embolus</b> DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Adenocarcinoma of Breast</b> DUE TO lost. (c) <b>2 3 yrs.</b>									
INTERVAL BETWEEN ONSET AND DEATH <b>several months</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (This hospital) attended the deceased from <b>early 66</b> , 19, to <b>12/2</b> , 1967, that (I) (we) last saw the deceased alive on <b>11/29</b> , 1967, and that death occurred at <b>10:15 AM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>G. Leonard Gold</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. Leonard Gold</b>		22d. ADDRESS <b>9801 Georgia Ave., Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>		23d. LOCATION (City or Town) <b>Silver Spring, Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1331 Rock. Pike Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 6 1967</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17216		17214	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (RURAL)</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN lb <b>7mo 13 days</b>		d. STREET ADDRESS <b>500 S Ann st.</b>	
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROBERT LEE FILAR</b>		<b>First</b> <b>Middle</b> <b>Last</b>	<b>4. DATE OF DEATH</b> <b>16 December 1967</b>
<b>S. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Cauc</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <b>9 Aug 1948</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Military</b>	
<b>13. FATHER'S NAME</b> <b>ALFRED A. FILAR SR.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b> <b>17 Nov. 66</b>		<b>16. SOCIAL SECURITY NO.</b> <b>P13-54-3784</b>	
<b>17. INFORMANT</b> <b>LILLIAN JEAN FILAR 500 S Ann St., Baltimore Md</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (o), (b), and (c).)		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (o) 2041</b> <b>DUE TO</b> <b>(b) Chronic Myelogenous Leukemia</b> <b>DUE TO</b> <b>(c)</b>		<b>Hemorrhage</b> <b>7Mo</b>	
<b>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>3 May 1967</b> , to <b>16 Dec 1967</b> , that (I) (we) lost said the deceased alive on <b>16 Dec 1967</b> , and that death occurred at <b>240n M</b> , from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Charles S. Reeves</b>		<b>22b. DATE SIGNED</b> <b>12/30/67</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Charles S. Reeves Lt MC USN</b>		<b>22d. ADDRESS</b> <b>NAVAL HOSPITAL BETHESDA, MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/30/67</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Kaczrowski Funeral Home Baltimore, Md.</b>		<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <b>Holy Rosary Cemetery</b>	
<b>ADDRESS</b>		<b>23d. LOCATION (City or Town)</b> (County) (State) <b>Baltimore, Baltimore, Maryland</b>	
<b>25. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>DEC 26 1967 Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17217

CERTIFICATE OF DEATH

17215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY		
Bethesda		6 days		Rockville		Montgomery		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Suburban				263 Congressional La				
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day Year	
Ruth		F.		Jescher	Dec	19	1967	
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR	
F		W	<input type="checkbox"/> WIDOWED	<input checked="" type="checkbox"/> DIVORCED	4/19/1889	78	Months Doy Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife					Kentucky		U. S.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		Address Same as Item 2.			
Charles			Mary M. Vetter					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			
No					Mrs. Guy Smith			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO <i>ASHD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i> DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>10 yrs</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Thrombosis</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that (I) (this hospital) attended the deceased from <i>August 1964</i> to <i>12/19/67</i> , that (I) (we) last saw the deceased alive on <i>12/19/64</i> , and that death occurred at <i>1180</i> M, from causes and on the date stated above.								
22o. SIGNATURE <i>Robert C. Macon</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>12/19/67</i>								
22c. PHYSICIAN'S NAME (Type)		ROBERT C. MACON		22d. ADDRESS <i>809 Tiers Hill Rd.</i>				
Burial		23b. DATE THEREOF <i>12-22-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Hill Mem. Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Lynchburg, Virginia</i>		
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland						<i>Charles George</i>		
DATE <i>DEC 26 1967</i>								

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician. Then please remove carbon paper. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17218

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17216

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>VIRGINIA</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (RURAL)</b> b. LENGTH OF STAY IN 1b <b>19 DAYS</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICKSBURG</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>			e. STREET ADDRESS <b>1307 HANOVER ST.</b>					
3. NAME OF DECEASED (Type or print) <b>ERNEST FONDREN</b>			4. DATE OF DEATH Month <b>DECEMBER</b> Doy <b>16</b> Year <b>1967</b>					
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <b>9 March 1893</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Justice of Peace</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Marion, Alabama</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry J. Fondren</b>			14. MOTHER'S MAIDEN NAME <b>Information not available</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>1912-1945</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>Not known</b>	17. INFORMANT <b>Mrs. Nannie L. Fondren</b>	Address <b>1307 Hanover St.</b> Fredericksburg, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b>			INTERVAL BETWEEN ONSET AND DEATH					
163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PNEUMONITIS, DIFFUSE, BIILATERAL</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Fredericksburg</b> (County) <b>Virginia</b> (State) <b>19</b>
21. I certify that (I) (this hospital) attended the deceased from <b>27 Nov 1967</b> , to <b>16 Dec 1967</b> , that (I) (we) last saw the deceased alive on <b>16 Dec 1967</b> , and that death occurred at <b>955A</b> M, from causes and on the date stated above.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. SIGNATURE <b>E. Perlin</b>			M.D. <b>E. Perlin</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>16 Dec 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. Perlin, Lcdr MC USN</b>			22d. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-18-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Sunset Memorial Gardens</b>	23d. LOCATION (City or Town) <b>Fredericksburg</b> (County) <b>Virginia</b> (State)				
24. FUNERAL DIRECTOR <b>WHEELER AND THOMPSON</b>			ADDRESS <b>FREDERICKSBURG, VA.</b>	25a. REC'D BY REGISTRAR <b>DEC 21 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17217

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
<i>Montgomery</i> MARYLAND		<i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>11106 Woodson Ave.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Yvonne</i>	Middle <i>M.</i>
Last <i>Massie</i>		4. DATE OF DEATH <i>December 7</i>	Month <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec. 20, 1893</i>	9. AGE (In years lost birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>England</i>	
13. FATHER'S NAME <i>Edward Jeffreys</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Mrs. Daphne Hill</i>		Address <i>11106 Woodson Avenue Kensington, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>6 months</i> <i>6 months</i>	
DUE TO <i>Congestive heart failure</i>			
DUE TO <i>Healed myocardial infarct</i>			
DUE TO <i>Aortic sclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>Annapolis</i>		(County) (State) <i>Annanolis</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1</i> , 1967 to <i>Dec 7</i> , 1967 that (I) (we) last saw the deceased alive on <i>Dec 7</i> , 1967, and that death occurred on <i>Dec 7</i> , 1967, from causes and on the date stated above.		22b. DATE SIGNED <i>12/7/67</i>	
22c. SIGNATURE <i>John J. Curry</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <i>10620 Georgia Avenue</i>		23d. LOCATION (City or Town) <i>Rockville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 9, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>Glen Carter</i>		25a. RECEIVED BY REGISTRAR <i>DEC 11 1967</i>	
ADDRESS <i>434 Georgia Avenue</i>		25b. REGISTRAR'S SIGNATURE <i>J. Warner E. Pumphrey, Inc.</i>	
DATE <i>Silver Spring, Md.</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

*M*  
W  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.  
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health.

17220		17218							
1. PLACE OF DEATH a. COUNTY <i>Montgomery Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		LENGTH OF STAY IN 1b <i>6 days</i>							
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suburban</i>		d. STREET ADDRESS <i>41 Westwood Lane</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Anthony</i>		First <i>A</i>	Middle <i>n</i>	Last <i>Torier</i>	4. DATE OF DEATH <i>Dec. 10 1967</i>	Month <i>Dec.</i>	Day <i>10</i>	Year <i>1967</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 30, 1909</i>		9. AGE (In years lost birthday) <i>58 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plant Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New Hampshire U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY <i>Panama</i>			
13. FATHER'S NAME <i>Joseph Torier</i>		14. MOTHER'S MAIDEN NAME <i>Lorraine Harris</i>		15. INFORMANT <i>Mrs. Millie Cox</i>		16. SOCIAL SECURITY NO. <i>003-07-1911</i>		17. INFORMANT <i>Mrs. Millie Cox</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction, Recent &amp; Remote</i>		DUE TO <i>4201</i>		DUE TO <i>Coronary arteriosclerosis with occlusion</i>		DUE TO <i>Po</i>		INTERVAL BETWEEN ONSET AND DEATH <i>ACUTE 20 MIN.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Esophago-gastrostomy, post 5 days, for carcinoma esophagus</i>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
								20f. (City or town) <i>(County)</i> <i>(State)</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Nutrol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>Dec. 12, 1967</i>			
EXAMINER'S NAME (Type) <i>John G. Ball Bethesda, Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/14/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City or Town) <i>(County)</i> <i>(State)</i> <i>Silver Spring, Md.</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>		ADDRESS <i>1331 Rockville Pike Rockville, Maryland</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR ATSMC 6M 1/67									

located. Please mail original information

to: Director of Information Services, Department

of Defense, Washington, D.C. 20330. Your information will be held in strict confidence.

Information concerning your investigation or investigation of other cases may be furnished to you at any time.

Information concerning your investigation or investigation of other cases may be furnished to you at any time.

WILSON INFORMATION CENTER  
DEPARTMENT OF DEFENSE

Washington, D.C. 20330. Please send to: WILSON INFORMATION CENTER  
DEPARTMENT OF DEFENSE, WASHINGTON, D.C. 20330.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17219

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Springfield</i>		c. LENGTH OF STAY IN lb <i>3 days</i>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington, D.C.</i>	b. COUNTY	
				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colonial Villa Nursing Home</i>	d. STREET ADDRESS <i>3636 S. Street, N.W.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
47.3		4. DATE OF DEATH <i>December 9, 1967</i>		5. NAME OF DECEASED First <i>CAROLINE</i> Middle <i>H</i> Last <i>FOSTER</i>	Month	Doy	Year
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-27-82</i>	9. AGE (In years lost birthday) <i>85 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Hiram G. Hotchkiss</i>		14. MOTHER'S MAIDEN NAME <i>Louise W. Knowles</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>Mary L. Charles</i>		Address <i>3636 S St. NW Wash. DC</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4200</i>		(b) <i>Generalized Arteriosclerosis</i>	20 yrs.				
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Asteoarthritis, generalized, Fracture l. hip.</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>January 1965</i> , to <i>12/9</i> , 1967, that (I) (we) last saw the deceased alive on <i>12/9</i> , 1967, and that death occurred at <i>5:15 PM</i> , from causes and on the date stated above.							
22. SIGNATURE <i>Seymour Greenbaum</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/9/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Seymour Greenbaum</i>		22d. ADDRESS <i>M.D. 1800 Eye St. N.W. Washington, D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		23b. DATE THEREOF <i>12/11/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	23d. LOCATION (City or Town) <i>Suitland, Md.</i>	(County) <i>—</i>	(State) <i>—</i>	
24. FUNERAL DIRECTOR <i>Joseph Lawlor's Sons</i>		ADDRESS <i>5130 Wisconsin Ave. NW Washington, DC</i>		25a. REC'D BY REGISTRAR <i>Charles J. Charles</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Charles</i>		

OUR FIGHT IS ON

WE ARE GOING TO WIN

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
17222 Item #23c Film #396 12/20/67 km 17220 Item #23b Film #396 12/20/67 km CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE South Carolina b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 61 62 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lyman			77-3								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland						d. STREET ADDRESS 8 Crest Street											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Mary			Middle Ruth			Last Fowler			4. DATE OF DEATH December 17 1967	Month	Day	Year					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 8 January 1915		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stitcher				10b. KIND OF BUSINESS OR INDUSTRY Printing				11. BIRTHPLACE (County & State, or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Ray Powell						14. MOTHER'S MAIDEN NAME Mary A. Case											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Not available				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland									
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Aspergillosis INTERVAL BETWEEN 201X ONSET AND DEATH 2 weeks DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain abscess weeks DUE TO (c) Hodgkin's Disease post radiotherapy 3 years																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)													
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Greer (County) S.C. (State)									
21. I certify that (X) (this hospital) attended the deceased from Oct. 16, 1967, to Dec. 17, 1967, that (X) (we) last saw the deceased alive on Dec. 17, 1967, and that death occurred at 11:00M, from causes and on the date stated above.																	
22a. SIGNATURE F. Grumet MD						A. M. MED. STAFF M.D. ATTENDING PHYS. DIRECTOR PHYS. <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>						22b. DATE SIGNED 1967 17 December					
22c. PHYSICIAN'S NAME (Type) Frank C. Grumet, MD						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014											
23a. BURIAL CREMATION, REMOVED			23b. DATE THEREOF Dec 18 1967			23c. NAME OF CEMETERY OR CREMATORIAL Wood Mem. Park, Route 6			23d. LOCATION (City or Town) (County) (State) Greer, S.C. Spartanburg Co								
24. FUNERAL DIRECTOR Joseph Gawler's Sons 5130 Wisc, Ave. N.W. Wash.						ADDRESS D.C. 25a. REC'D BY REGISTRAR DATE DEC 26 1967						25b. REGISTRAR'S SIGNATURE Charles Judge					

SCSI

2

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

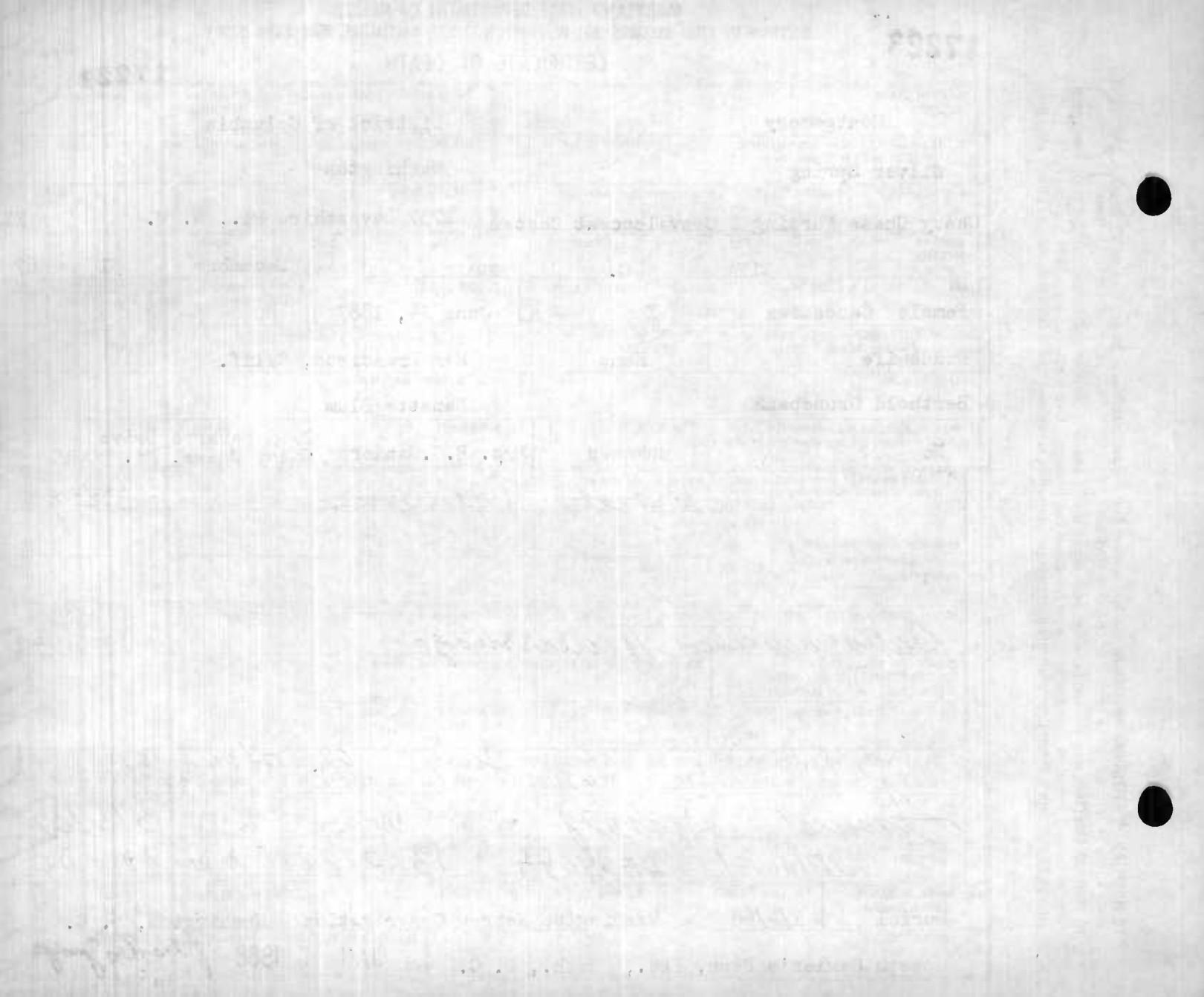
17223

CERTIFICATE OF DEATH

17221

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>District of Columbia</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>2737 Devonshire Pl., N. W.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chevy Chase Nursing &amp; Convalescent Center</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>RITA</b>		First	Middle	Last	4. DATE OF DEATH <b>December</b>	Month	Doy	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1887</b>	9. AGE (In years lost birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>San Francisco, Calif.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Berthold Grunebaum</b>		14. MOTHER'S MAIDEN NAME <b>Nanette Blum</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Mrs. B.C. Sanders</b>		Address <b>2705 Navarre Drive</b> <b>Chevy Chase, Md. 20015</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>491X</i>		<i>Broncho - Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Subarachnoid hemorrhage -</i>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
19								
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>61</b> to <b>12/31</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>12/31</b> , 19 <b>67</b> , and that death occurred at <b>345P</b> M, from causes and on the date stated above.								
22a. SIGNATURE <i>Samuel Dessoff</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/31/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>SIMUEL DESSOFF</b>		22d. ADDRESS <b>1302-18ST-N.W. MSHDC</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/4/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Washington Hebrew Congregation</b>		23d. LOCATION (City or Town) <b>Washington, D. C.</b>		(County) (State)
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., Wash., D. C.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 5 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>		



**15** To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**17224** MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 Film G396 1/5/68 1dc

**CERTIFICATE OF DEATH**

**17222**

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
<i>Montgomery</i> <i>Maryland</i>		<i>Maryland</i> <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Parklawn Cemetery</i> <i>Blk # - 5 Sharon Woods</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>William</i>	Middle <i>E.</i>
Last <i>Franklin</i>		4. DATE OF DEATH Month <i>Dec</i> Doy <i>25</i> Year <i>1967</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 36 (In years old, birthday) <i>3/16/31</i> 76 yrs.	
NEVER MARRIED <input type="checkbox"/>		9. ADDRESS <i>5 Stone Asylum</i>	
DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Florida</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Grady Thompson Franklin</i>		14. MOTHER'S MAIDEN NAME <i>Frances Kirkpatrick</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No!</i>		16. SOCIAL SECURITY NO. <i>261-369239</i>	
17. INFORMANT <i>Chart / Carol Jean Franklin</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid &amp; Intrapontine hemorrhage, spontaneous</i> DUE TO <i>330X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Ruptured congenital aneurysm, right cerebellar artery <i>11 days</i>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-17</i> , 19 <i>67</i> , to <i>12-25</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12-25-67</i> , and that death occurred at <i>8218 Wisconsin Ave Bethesda MD</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>12/26/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Francis C. Mayle Jr. MD</i>		22d. ADDRESS <i>8218 Wisconsin Ave Bethesda MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-28-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. ADDRESS <i>Judge</i>	
		25b. REC'D BY REGISTRAR DATE <i>DEC 29 1967</i>	

1931

20212

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						17223					
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND			<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1004 DeBeck Drive</b>			d. STREET ADDRESS <b>1004 DeBeck Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Rose</b> First <b>Anne</b> Middle <b>Frazier</b>		Lost	<b>4. DATE OF DEATH</b> <b>December 16, 1967</b>		Month <b>December</b> Doy <b>16</b> Year <b>1967</b>						
<b>S. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 10, 1883</b>		9. AGE (In years last birthday) <b>84</b> yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Benjamin Thomas</b>			14. MOTHER'S MAIDEN NAME <b>Mary Katherine Cooley</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Phoebus - Niece - 541 Brent Road</b>			Address <b>Rockville, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral decompression &amp; myocardial failure</i> DUE TO <i>4221</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO			(c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <i>None</i>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>								
20c. TIME OF INJURY Month Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rockville</b> (County) <b>Maryland</b> (State) <b>Md.</b>				
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1966, 19</b> to <b>Dec 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 15, 1967</b> , and that death occurred <b>at 12:45 A.M.</b> from causes and on the date stated above.											
22a. SIGNATURE <i>W.A. Scatturini</i>			M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.			22b. DATE SIGNED <i>12/17/67</i>					
22c. PHYSICIAN'S NAME (Type) <b>W.A. Scatturini, MD</b>			22d. ADDRESS <i>110 S. Washington St. Rockville, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/19/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Clarksburg Cemetery</b>		23d. LOCATION (City or Town) <b>Clarksburg, Maryland</b>		(County) <b>Maryland</b> (State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>			ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>			25a. REC'D BY REGISTRAR <b>DEC 21 1967</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Juges</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17226

CERTIFICATE OF DEATH

17226

- To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Montgomery Maryland		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 3 days/12 1/2 hrs	
Takoma Park		Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 402 Lexington Drive	
Washington Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Marian	Middle Esther
Last Frech		4. DATE OF DEATH	Month December 21, 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. ODE OF BIRTH 7-9-90		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWT.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albertus Wilson		14. MOTHER'S MAIDEN NAME Cora	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 72-18-54- 17. INFORMANT <del>WILLIE FRECH</del> Hospital Records Address 2nd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 IX		INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		Generalized arterio sclerosis Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966, 19, to December 21, 1967, that (I) (we) last saw the deceased alive on December 20, 1967, and that death occurred at 23A M, from causes and on the date stated above.			
22a. SIGNATURE Bennet A. Porter Jr.		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> ME.O. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED December 21, 1967
22c. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.		22d. ADDRESS 9301 Colesville Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 23, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State) Washington D.C.		23e. REC'D BY REGISTRAR DATE DEC 28 1967	
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc.		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 8434 Georgia Ave. Silver Spring, Md.			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17225

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

*(Cleared by medical examiner)*

1. DECEASED NAME (Type or print)		First <b>KATE</b>	Middle <b>CLYDENIN</b>	Last <b>FREEMAN</b>	20. DATE OF DEATH Month <b>12</b>	Doy <b>26</b>	Year <b>67</b>	2b. HOUR <b>800</b>
3. SEX <b>F</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH <b>12-10-1883</b>			6. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR MONTHS <b>84</b>	IF UNDER 24 HRS. DAYS <b>84</b>	2b. HOUR <b>800</b>
7. BIRTHPLACE (State or foreign country) <b>ALAMANCE Co., NC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b>			
10. CITY OR TOWN OF DEATH <b>WATERTOWN</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>UNIVERSITY NURSING</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>GENERAL OFFICE WORKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>8607 PINE/BRANCH</b>				
14. FATHER'S NAME First <b>HAYWOOD</b>	Middle <b>CLYDENIN</b>	Last	15. MOTHER'S MAIDEN NAME First <b>CALLIE?</b>	Middle	Last <b>(Unknown)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>579-28-0429</b>	17. INFORMANT <b>J. Richard Sweeney</b>	Address <b>9203 Twoood Street Silver Spring, Md.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> <b>4200</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Arteriosclerotic heart disease</b> (b) <b>years</b> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Iron deficiency anemia; cholelithiasis</b>								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (his hospital) attended the deceased from <b>March 1962</b> to <b>12-26, 1967</b> , that (I) (we) last saw the deceased alive on <b>12-7 1967</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John Geiger, M.D.</i>								
22d. PHYSICIAN'S NAME (Type) <i>JOHN GEIGER, M.D.</i>	22e. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>12-26-67</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 29, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>			23d. LOCATION (City or Town) <b>Prince Georges Co., Md.</b>	(County)	(State)	
24. FUNERAL DIRECTOR <b>Thomas John Barnes</b>	ADDRESS <b>8432 Georgia Ave.</b>	25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>			25b. REGISTRAR'S SIGNATURE <i>George</i>			
30M REV. 1/68								

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>10 1/2 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>		d. STREET ADDRESS <i>5480 Wisc-Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hosp.</i>						d. STREET ADDRESS <i>Hughland House</i>								
3. NAME OF DECEASED (Type or print)		First <i>IDA</i>	Middle <i>Friedman</i>	Last <i></i>	4. DATE OF DEATH <i>Dec 28</i>	Month <i></i>	Doy <i></i>	Year <i>1967</i>						
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/2/1909</i>	9. AGE (In years lost birthday) yrs. <i>58</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Supt Store</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Zachary</i>			14. MOTHER'S MAIDEN NAME <i>ABRAMOWITZ</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i></i>			16. SOCIAL SECURITY NO. <i></i>			17. INFORMANT <i>Gertrude Epstein</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intracranial hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cerebral arteriosclerosis</i> DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF DEATH Month, Day, Year Hour a.m. p.m. <i>Dec 28 1967</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>27 Dec 1967</i> to <i>28 Dec 1967</i> , that (I) (we) last saw the deceased alive on <i>27 Dec 1967</i> , and that death occurred at <i>8:50 AM</i> , from causes and on the date stated above.														
22a. SIGNATURE <i>Horace (O) Bernton</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>12/28/67</i>								
22c. PHYSICIAN'S NAME (Type) <i>Horace W. Bernton</i>			22d. ADDRESS <i>4743 Bradley Blvd. Ch. Ch. Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-29-67</i>		23c. NAME OF CEMETERY, OR CREMATORIAL <i>King David NEU-Garden</i>		23d. LOCATION (City or Town) <i>Falls Church</i>		(County) <i>Virginia</i>		(State)				
24. FUNERAL DIRECTOR <i>Berney &amp; Sons</i>		ADDRESS <i>3501 1/2 E. 18th St.</i>		25a. REC'D BY REGISTRAR <i>JAN 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>judge</i>								

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

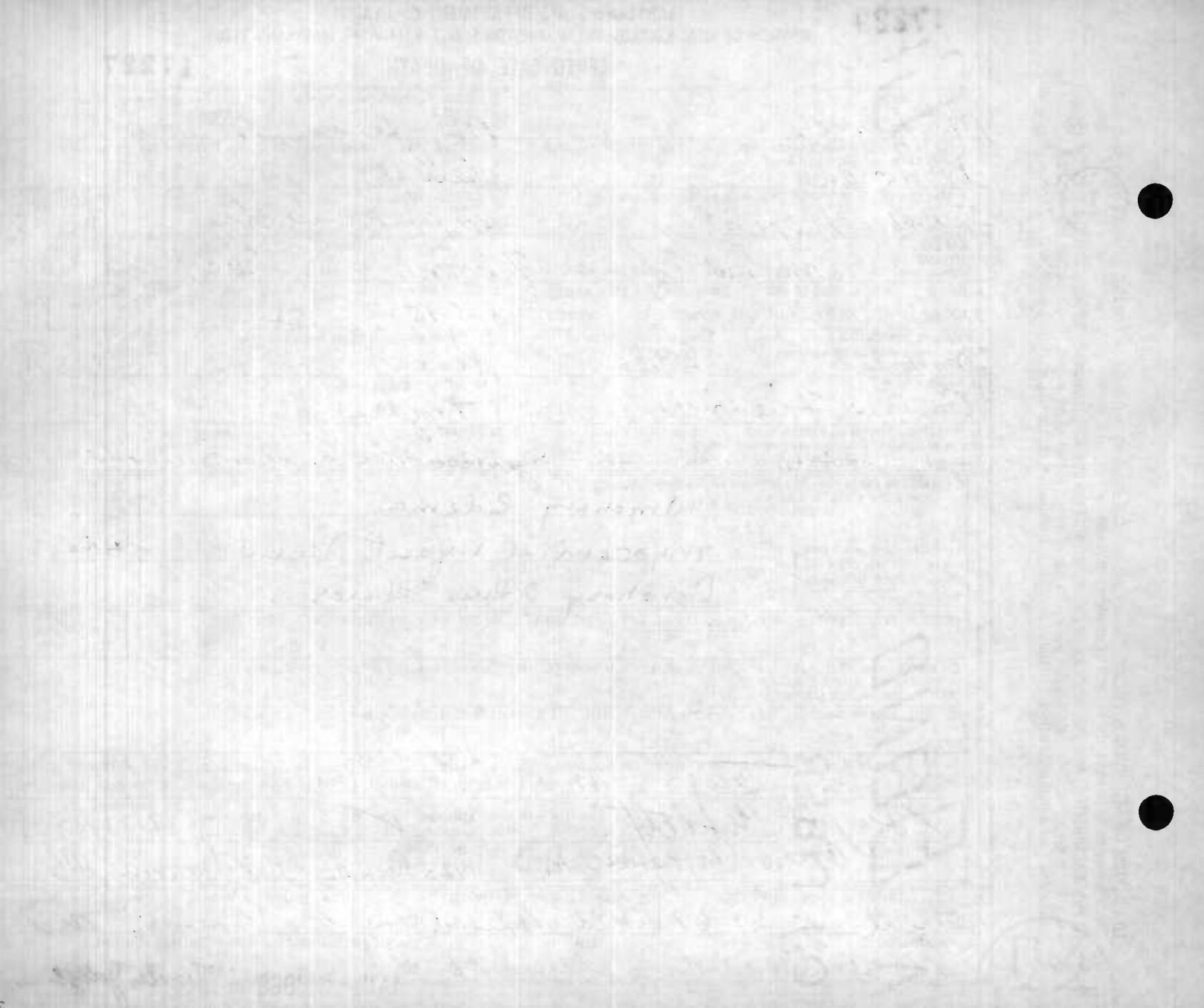
## **CERTIFICATE OF DEATH**

17227

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saurel</i>	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>41 Meadow Lane</i>	
3. NAME OF DECEASED (Type or print)	First <i>Andrew</i>	Middle <i>Edmund</i>	Last <i>Friedrich</i>
4. DATE OF DEATH Month <i>Dec</i>	Month <i>28</i>	Day <i>1967</i>	Year
S. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>8-5-15</i>	9. AGE (In years lost birthday) <i>52</i> yrs.	IF UNDER 1 YEAR Months <i>52</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Draftsman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Geico</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Andrew Friedrich</i>	14. MOTHER'S MAIDEN NAME <i>Kydra</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	16. SOCIAL SECURITY NO. <i>411-12-1212</i>	17. INFORMANT <i>Janetta Friedrich wife add son</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>pulmonary edema</i>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <i>myocardial infarct, recent</i>			<i>4 days</i>
DUE TO (c) <i>Coronary Atherosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1967, to <i>Dec 23</i> , 1967, that (I) (we) last saw the deceased alive on <i>Dec 23</i> 1967, and that death occurred at <i>6:00 A.M.</i> from causes and on the date stated above			
22a. SIGNATURE <i>George H. Mitchell</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/23/67</i>
22c. PHYSICIAN'S NAME (Type) <i>GEORGE H. MITCHELL, M.D.</i>	22d. ADDRESS <i>11125 Rockville Pike, Rockville, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-27-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Balt. National Cem.</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>
24. FUNERAL DIRECTOR <i>DeWitt Cannon</i>	ADDRESS <i>Diamond Laurel Md.</i>	25a. REC'D BY REGISTRAR <i>JAN 3 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Merle George</i>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17228

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**11 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17230		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17228		
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN lb <i>3 months</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. STATE <i>Maryland</i> e. COUNTY <i>Montgomery</i> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring (Hillendale)</i> g. STREET ADDRESS <i>1616 Oaklawn Court</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (Nat in hospital, give street address) <i>Colonial Villa 13325 New Hampshire Ave</i>		3. NAME OF DECEASED (Type or print) <i>Carrie FRENCH Froehlick</i>			First <i>C</i>		Middle <i>FRENCH</i>		Last <i>Froehlick</i>		4. DATE OF DEATH <i>12 - 28 - 67</i>		Month <i>12</i> Day <i>28</i> Year <i>67</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>Wh-</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-21-1886</i>		9. AGE (In years last birthday) <i>81 yrs.</i>		IF UNDER 1 YEAR Months <i>0</i> Dots <i>00</i> Hours <i>00</i> Min. <i>00</i>		IF UNDER 24 HRS. Months <i>0</i> Dots <i>00</i> Hours <i>00</i> Min. <i>00</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Clerk</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Agriculture</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Michigan</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Lucius French</i>					14. MOTHER'S MAIDEN NAME <i>Anna (unknown)</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>579-44-6843</i>			17. INFORMANT <i>Hillendale Maryland</i> <i>Sarah F. Mears-1616 Oaklawn Court</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Wheaton</i> (County) <i>Maryland</i> (State) <i>MD</i>							
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 2</i> , 1967, to <i>12/28, 1967</i> , that (I) (we) last saw the deceased alive on <i>DEC 19 1967</i> , and that death occurred at <i>10:40 A.M.</i> from causes and on the date stated above.														
22a. SIGNATURE <i>B.G. Bendler</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <i>12/28/67</i>				
22c. PHYSICIAN'S NAME (Type) <i>B.G. Bendler</i>					22d. ADDRESS <i>10820 Georgia Avenue, Wheaton, Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 2, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL ESTATE <i>C. Glen Carter 8434</i>			23d. LOCATION (City or Town) <i>Suitland</i> (County) <i>Maryland</i> (State) <i>MD</i>							
23e. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc. Silver Spring, Md</i>					23f. ADDRESS <i>Ga. Avenue</i>		23g. REC'D BY REGISTRAR <i>JAN 8 1968</i>		23h. REGISTRAR'S SIGNATURE <i>Charles Jones</i>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17231		17229	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11313 Old Club Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First Cecil Middle Forest Last Frost</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> , Year <b>1967</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/16/05</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR <b>Months</b> Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Cecil R. Frost</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>If yes give war or dates of service</b>		16. SOCIAL SECURITY NO. <b>532-09-7948</b>	
17. INFORMANT <b>Cecil R. Frost-son same item # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>203X</b> DUE TO <b>multiple myeloma</b> INTERVAL BETWEEN ONSET AND DEATH <b>13 months</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>Aug 25</b> , 19 <b>67</b> , to <b>12-21</b> , 19 <b>67</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>12-8</b> 19 <b>67</b> , and that death occurred at <b>630 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Alfred S. Norton</b>		22b. DATE SIGNED <b>12/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Alfred S. Norton, M.D.</b>		22d. ADDRESS <b>7710 Dwight Drive, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/23/67</b>	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) (County) (State) <b>Woodland Yolo Calif.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home Rockville, Md.</b>		25. REC'D BY REGISTRAR <b>1351 Rockville Pike</b>	
		26. REGISTRAR'S SIGNATURE <b>Judge</b>	

1791

baseball

baseball

baseball

baseball

baseball and football

baseball and football

baseball

baseball

baseball

baseball

baseball

baseball

baseball

baseball

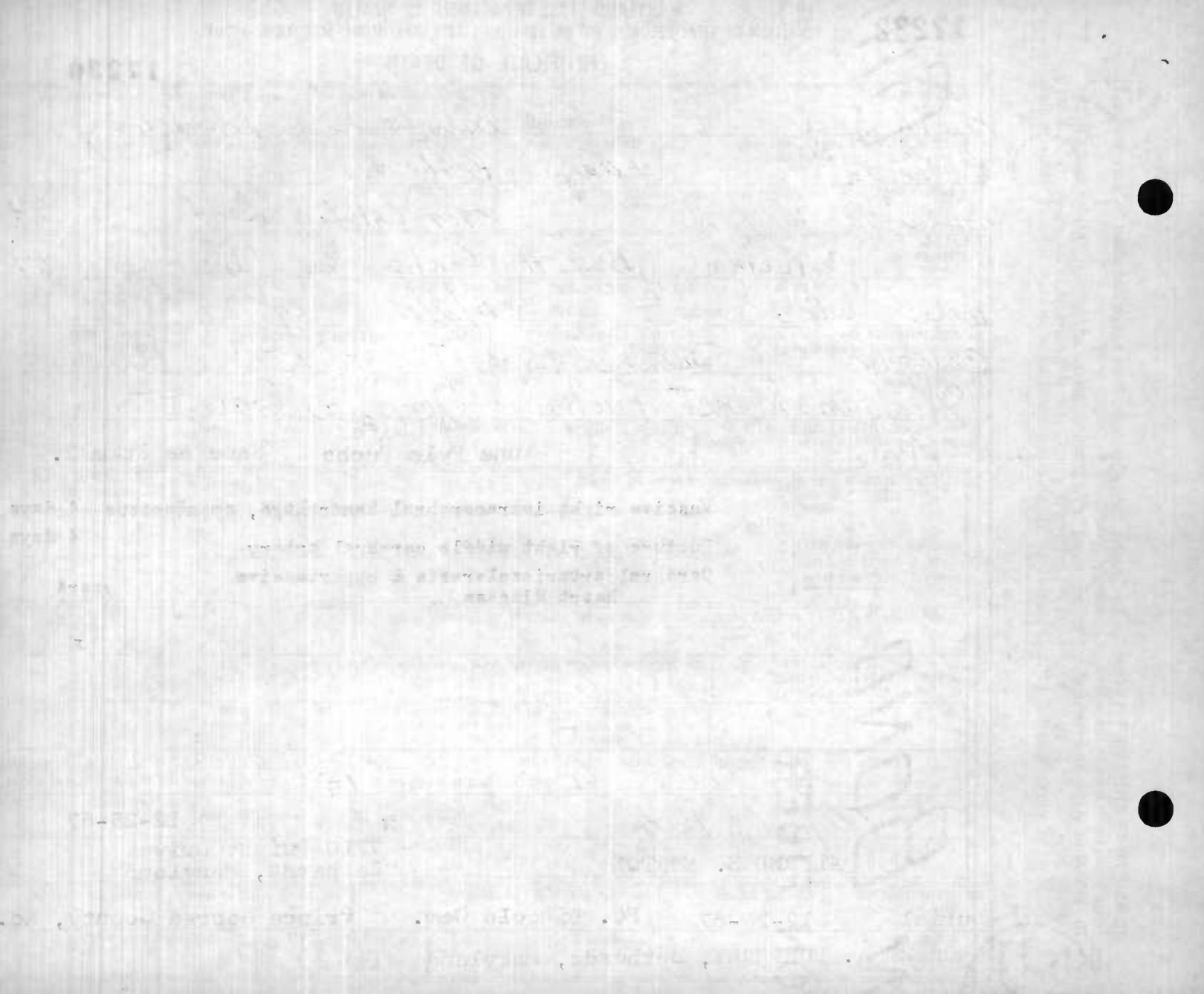
baseball

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**1**  
**17232**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>												<b>17230</b>		
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>						<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Maryland</u> b. COUNTY <u>Maryland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5907 Holston Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>3. NAME OF DECEASED</b> <small>(Type or print)</small> <u>William</u>		First	Middle	Last	<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>25</u> Year <u>1967</u>									
S. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/08</u>	9. AGE (In years last birthday) yrs. <u>59</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Counselor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>District School System</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>William Robert Fuchs</u>			14. MOTHER'S MAIDEN NAME <u>Georgia Barrett</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.			17. INFORMANT <u>Wife</u> <u>Anne Pyle Fuchs</u>			Address <u>Same as Item 2.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive right intracerebral hemorrhage, spontaneous</u> DUE TO <u>33dX</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Rupture of right middle cerebral artery</u> DUE TO <u>33dX</u> <u>4 days</u> (c) <u>Cerebral arteriosclerosis &amp; Hypertensive heart disease</u> DUE TO <u>33dX</u> <u>years</u>														
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>														
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7710 Dwight Drive Bethesda, Maryland</u>		20f. (City or town) <u>7710 Dwight Drive Bethesda, Maryland</u>		(County) <u>Prince George County, Md.</u>		(State) <u>MD</u>				
<b>21. I certify that</b> <u>(1)</u> <b>this hospital</b> attended the deceased from <u>Nov. 1962</u> , to <u>Dec 25, 1962</u> , that <u>(1)</u> <b>(we)</b> last saw the deceased alive an <u>Dec 24 1967</u> , and that death occurred at <u>155 M</u> , from causes and on the date stated above.														
<b>22a. SIGNATURE</b> <u>Alfred S. Norton</u>														
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ALFRED S. NORTON</u>		<b>M.D.</b> <input checked="" type="checkbox"/> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12-25-67</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-28-67</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Ft. Lincoln Cem.</u>		23d. LOCATION (City or Town) <u>Prince George County, Md.</u>		(County) <u>Prince George County, Md.</u>		(State) <u>MD</u>				
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>Michael Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Michael Judge</u>								
VR A15 (4) 25M 1/67				DATE <u>DEC 29 1967</u>										



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17233		17231	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN lb <b>3 days</b>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> o. STATE <b>New Jersey</b> b. COUNTY <b>C</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pitman</b> d. STREET ADDRESS <b>57-Colonial Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
f. FIRST MIDDLE LAST <b>EDWARD ROY GARLAND</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>December 5, 1967</b>	
g. SEX <b>m</b> h. COLOR OR RACE <b>w</b>		i. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
j. 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Purchasing Agent</b>		k. 10b. KIND OF BUSINESS OR INDUSTRY <b>PENNS R.R.</b>	
l. 13. FATHER'S NAME <b>Unknown</b>		m. 14. MOTHER'S M AIDEN NAME <b>Unknown</b>	
n. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		o. 16. SOCIAL SECURITY NO. <b>YES</b>	
p. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Pulmonary edema</b> (b) <b>Myocardial infarct</b> DUE TO <b>2 1/2 days</b>		q. 17. INFORMANT <b>Mrs. Jeanette Garland</b> Address <b>87 Colonial Ave., Pitman, New Jersey</b> INTERVAL BETWEEN ONSET AND DEATH <b>Chrs</b>	
r. 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		s. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
t. 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		u. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Washington Twp.</b> (County) <b>New Jersey</b> (State)	
v. 21. I certify that (I) (this hospital) attended the deceased from <b>12/2</b> , 19 <b>67</b> , to <b>12/5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/4</b> , 19 <b>67</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.		w. 22b. DATE SIGNED <b>12/5/1967</b>	
x. 22a. SIGNATURE <b>Richard Delaney</b>		y. 22d. ADDRESS <b>4323 Howard St., Silver Spring, Md.</b>	
z. 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Renewal</b>		b. DATE THEREOF <b>Dec. 7, 1967</b>	
c. 24. FUNERAL DIRECTOR <b>Charles Carter</b> <b>C. Glen Carter</b>		d. NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Memorial Park</b> ADDRESS <b>8434 Georgia Avenue, Silver Spring, Maryland</b>	
e. 25a. REC'D BY REGISTRAR <b>Charles Judge</b> DATE <b>DEC 11 1967</b>		f. 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

16242

HAWAIIAN

PEST

giant weta

adult

adult female

immature female

immature female

immature female

giant weta

adult female

adult female

adult female

adult female

adult female

giant weta

adult female

adult female

adult female

adult female

adult female

W m

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>21 DAYS</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>				e. STREET ADDRESS <b>9933 MOSS AVE.</b>											
3. NAME OF DECEASED (Type or print) <b>Gwendoline</b>				4. DATE OF DEATH Month Day Year <b>DEC. 28 1967</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/17/95</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED GOLF.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Labor Consultant</b>				11. BIRTHPLACE (County & State, or foreign country) <b>ENGLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Matthew Geach</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>yes</b>				17. INFORMANT <b>Norine Diamond</b>				Address <b>521 Dartmouth Avenue Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatous invasion of Liver</b> (c) <b>Primary Carcinoma of Stomach</b>												INTERVAL BETWEEN ONSET AND DEATH <b>approx 6 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>White at work</b>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 7, 1967</b> , to <b>Dec. 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec. 27, 1967</b> , and that death occurred at <b>6101 M.</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Gene U. Collier, M.D.</b>												22b. DATE SIGNED <b>Dec 28 67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Gene U. Collier, M.D.</b>				22d. ADDRESS <b>1106 Scott St. Silver Spring, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>Dec. 29, 1967</b>				23c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Crematory</b>				23d. LOCATION (City, town or county) (State) <b>Prince Georges Co. Md.</b>			
24. FUNERAL DIRECTOR <b>John B. Thomas, Jr. Warren E. Pumphrey, Inc.</b>				ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles J. Hayes</b>			

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WILDFLOWERS

201392 26/12

PLANT NAME

316 223 223 223

NAME (201392)

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

*M*

17235

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17233

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		17235		2		17233	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		3. NAME OF DECEASED		4. DATE OF DEATH	
a. COUNTY		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		First		Month Day Year	
Montgomery		Laytonsville		Middle		Dec. 5 1967	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		5. SEX		5. SEX	
Baltimore		15 mins.		Male		Female	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		6. COLOR OR RACE		7. MARRIED		7. MARRIED	
Suburban		White		<input checked="" type="checkbox"/> NEVER MARRIED		<input type="checkbox"/> DIVORCED	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	
Truck Driver		Maryland Const		April 6, 1927		40	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Augustus Thomas Gibson Sr.		Beatrice Barber		Maryland		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
No		578-36-2944		Charlotte Gibson		Coronary Insufficiency Acute -	
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
4201				(b)		1 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO			
				(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12/5/67	
EXAMINER'S NAME (Type) John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-8-67		23c. NAME OF CEMETERY OR CREMATORIALaytonsville		23d. LOCATION (City or Town) (County) (State) Laytonsville, Mont. Md.	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 7 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1188-1-100

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## 17236 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

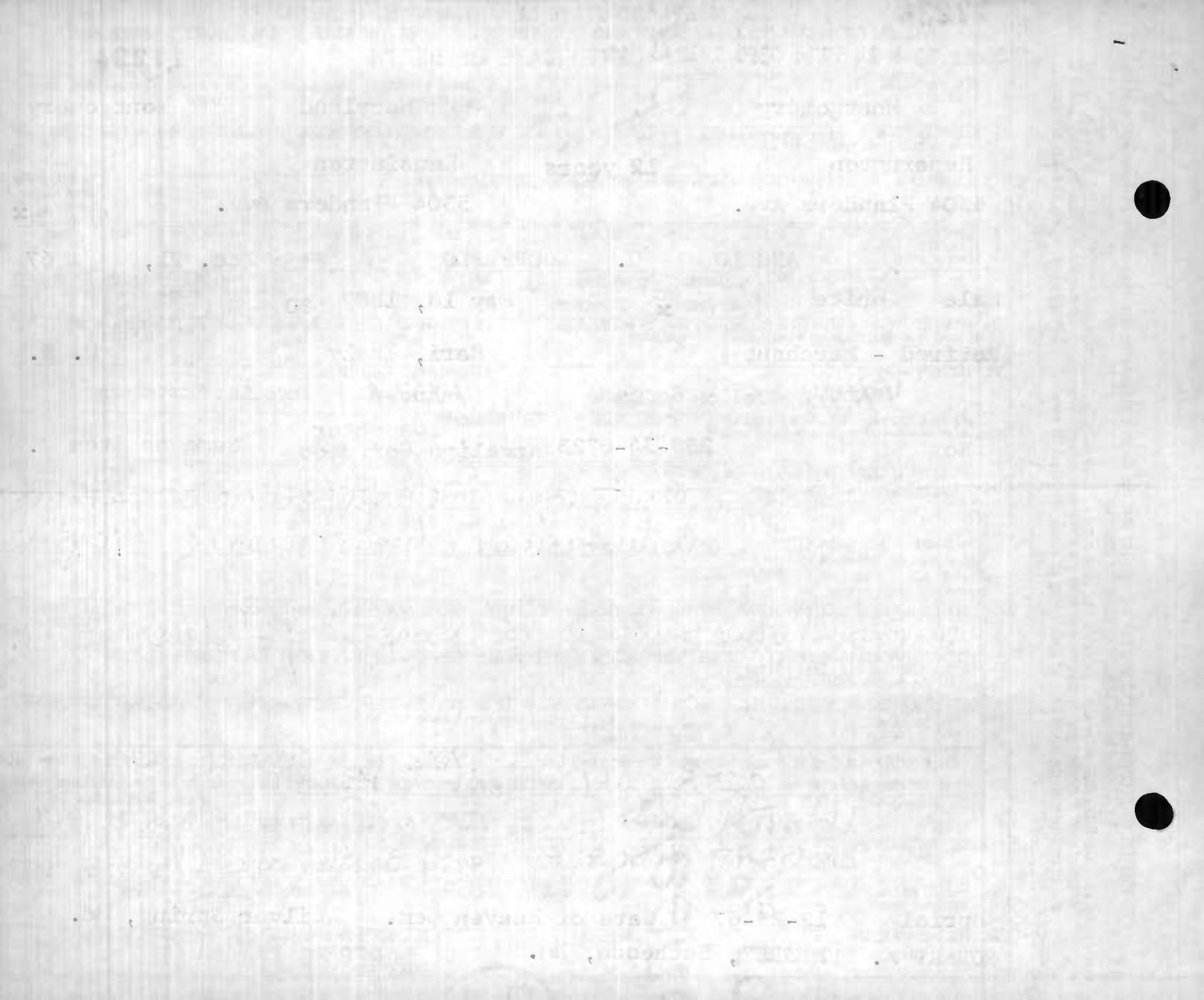
Items 13 &amp; 14 Film G396 1/12/68 CERTIFICATE OF DEATH

17234

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 pages and 2 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>12 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5304 Flanders Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANGELO G. GOFFREDO</b>		First	Middle	Last	4. DATE OF DEATH <b>Dec. 21, 1967</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1887</b>	9. AGE (In years last birthday) <b>80 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Bari, Italy</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Felice Goffredo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-54-6723</b>		17. INFDRMT Daughter Angelina Goffredo	
				Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>Acute congestive heart failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerotic heart disease</b> (c) <b>10 years.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>① Phlebitis vulgaris ② Calculus of bladder</b>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , 19, to <b>Dec. 21</b> , 1967, that (I) (we) last saw the deceased alive on <b>Dec. 21</b> , 1967, and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Robert N. Coale</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec. 21, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>		22d. ADDRESS <b>4429 Bradley Lane Chevy Chase Md.</b>			
23a. BURIAL, CREMATION, REMoval (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-23-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cem.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Md.</b>		ADDRESS		23d. LOCATION (City, town or county) (State) <b>Silver Spring, Md.</b>	
				25a. REC'D BY REGISTRAR DATE <b>DEC 29 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>						17235			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			c. LENGTH OF STAY IN lb <b>13 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>William</b>	Middle <b>Samuel</b>	Last <b>Goodman</b>	4. DATE OF DEATH <b>December 30 1967</b>	Month <b>December</b>	Doy <b>30</b>	Year <b>1967</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-5-03</b>	9. AGE (In years lost birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Forman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Transit</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			
13. FATHER'S NAME <b>Samuel W. Goodman</b>			14. MOTHER'S MAIDEN NAME <b>Mary Moon</b>			12. CITIZEN OF WHAT COUNTRY? <b>America U.S.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>578 10 7813</b>			17. INFORMANT <b>Patient's chart</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>- Congestive heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Pneumonia, Pulmonary Emboli Suspected</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION			20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour: a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> to <b>Dec 30 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 29 1967</b> , and that death occurred at <b>2 AM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Gilbert B. Gasch</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-30-67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Francis Gasch's Sons Hyattsville, Md.</b>			22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/2/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P. C. Md.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		ADDRESS		25a. RECD BY REGISTRAR <b>JAN 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of the time of death.  
**11 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 2 Film G396 1/15/68 kk											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>12 hrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			d. STREET ADDRESS <u>10400 Montgomery Avenue</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Frederick S. Granger</u>		First	Middle	Lost	4. DATE OF DEATH <u>Dec 28 1967</u>	Month	Day	Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31 1884</u>			9. AGE (In years last birthday) <u>83</u> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Walter L. Granger</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Gilman</u>			Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.			17. INFORMANT			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Infarctions, pulmonary, bilateral</u>											
465X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.			DUE TO (b)								
			DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <u>10591 M</u> (County) <u>MD</u> (State)		
21. I certify that <u>I</u> (this hospital) attended the deceased from <u>12-27</u> , 19 <u>67</u> , to <u>12-28</u> , 19 <u>68</u> , that <u>I</u> (we) last saw the deceased alive on <u>12-28-67</u> 19 <u>68</u> , and that death occurred at <u>10591 M</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>J Thornton Boswell, M.D.</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>12-28-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>J Thornton Boswell, M. D.</u>			22d. ADDRESS <u>8600 OLD GEORGETOWN RD BETHESDA, MD</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 30, 1967</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Brainard Cemetery</u>			23d. LOCATION (City or Town) <u>Cranberry</u> (County) <u>New Jersey</u> (State)				
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		ADDRESS <u>BETHESDA, MD.</u>			25a. REC'D BY REGISTRAR <u>James J. ...</u>		25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>				
VR A15 (4) 25M 1/67					DATE <u>JAN 5 1968</u>						

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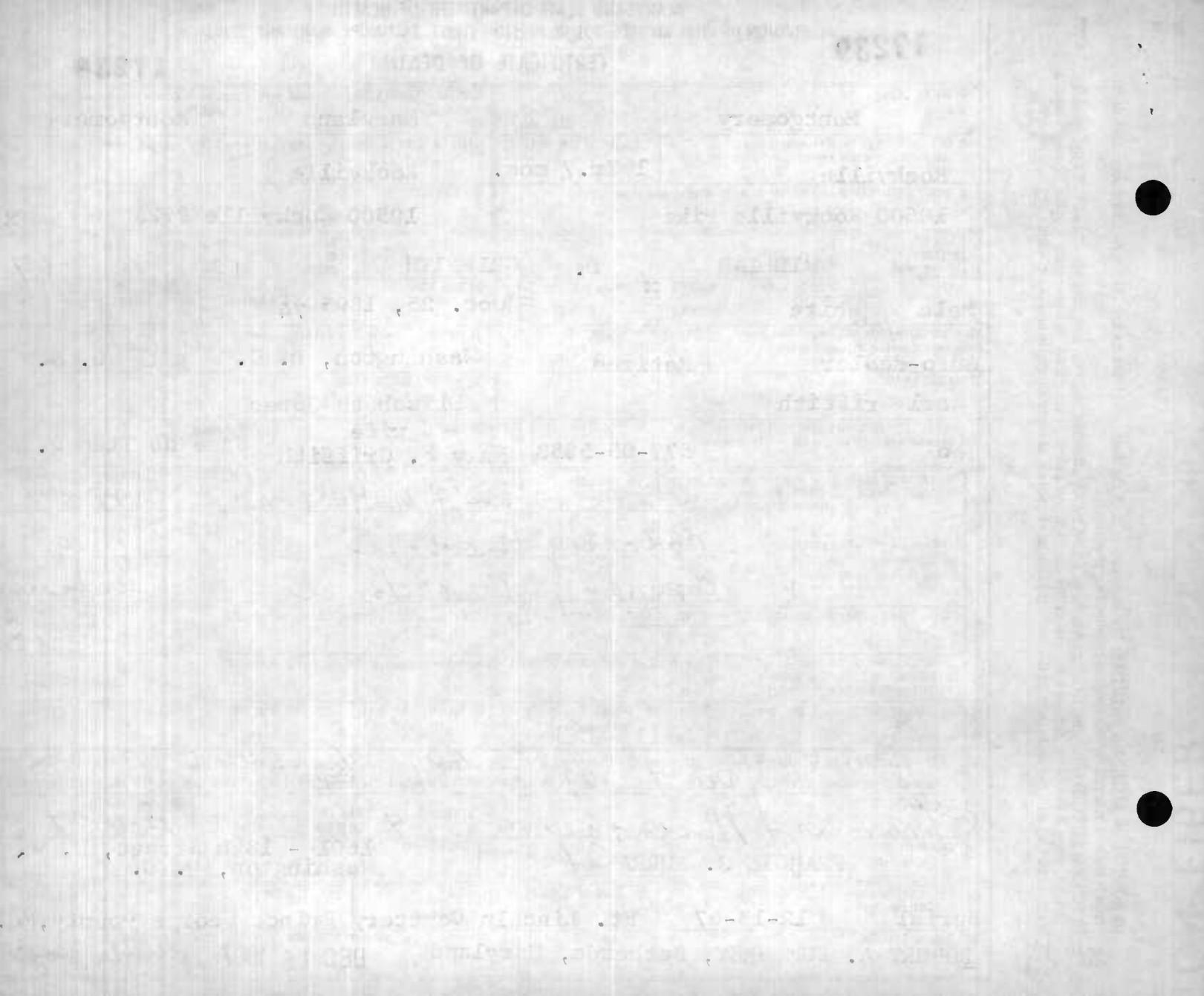
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH								17238			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN lb <b>1 Yr. 7 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10500 Rockville Pike</b>				d. STREET ADDRESS <b>10500 Rockville Pike</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>D.</b>	Middle <b>GRIFFITH</b>	Last		4. DATE OF DEATH <b>12 10 1967</b>		Month <b>12</b>	Day <b>10</b>	Year <b>1967</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 25, 1893</b>		9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto-dealer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Earl Griffith</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Jones</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> )			16. SOCIAL SECURITY NO. <b>577-03-5858</b>			17. INFORMANT wife <b>Mary F. Griffith</b>			Address <b>Same as Item 2.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b>											15 "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Coronary thrombosis</b>											15-20 "
(c) <b>Coronary atherosclerosis</b>											Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 1967, to <b>present</b> , 1967, that (I) (we) last saw the deceased alive on <b>Dec 7 1967</b> , and that death occurred at <b>1601 - 18th Street, N. W.</b> Washington, D. C.											22b. DATE SIGNED <b>12-11-67</b>
22a. SIGNATURE <b>Francis J. Murray</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. ADDRESS <b>1601 - 18th Street, N. W.</b> Washington, D. C.		
22c. PHYSICIAN'S NAME (Type) <b>FRANCIS J. MURRAY</b>			23b. DATE THEREOF <b>12-13-67</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Prince George County, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23e. ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>			25a. REC'D BY REGISTRAR DATE <b>DEC 15 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>											



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17239

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		d. STREET ADDRESS <b>4858 Battery Lane</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Medical</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>James D. HALSEY</b>		First	Middle	Last	4. DATE OF DEATH <b>12 June 1893</b>	Month	Doy	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 June 1893</b>	9. AGE (In years less birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Huntsville, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Robert S. Halsey</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Landmann</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Not Known</b>		16. SOCIAL SECURITY NO. <b>214 26 3521</b>		17. INFORMANT <b>Martha T. Halsey Bethesda, Md.</b>		4858 Battery Lane		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Atherosclerosis, Severe</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>23 DEC</b> , 19 <b>67</b> , to <b>27 DEC</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>27 December 1967</b> , and that death occurred at <b>6:15 PM</b> from causes and on the date stated above.								
22a. SIGNATURE <b>E. PERLIN</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>J. SODE</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>						
23a. BURIAL, CREMATION, BURIAL SPECIFY <b>BURIAL</b>		23b. DATE THEREOF <b>Dec 29, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; sons</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. G.</b>				
25c. DATE								

1000' off

surface

1000' off

(low) surface

100'

(low) surface

one meter 800'

bottom form.

1000' off

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

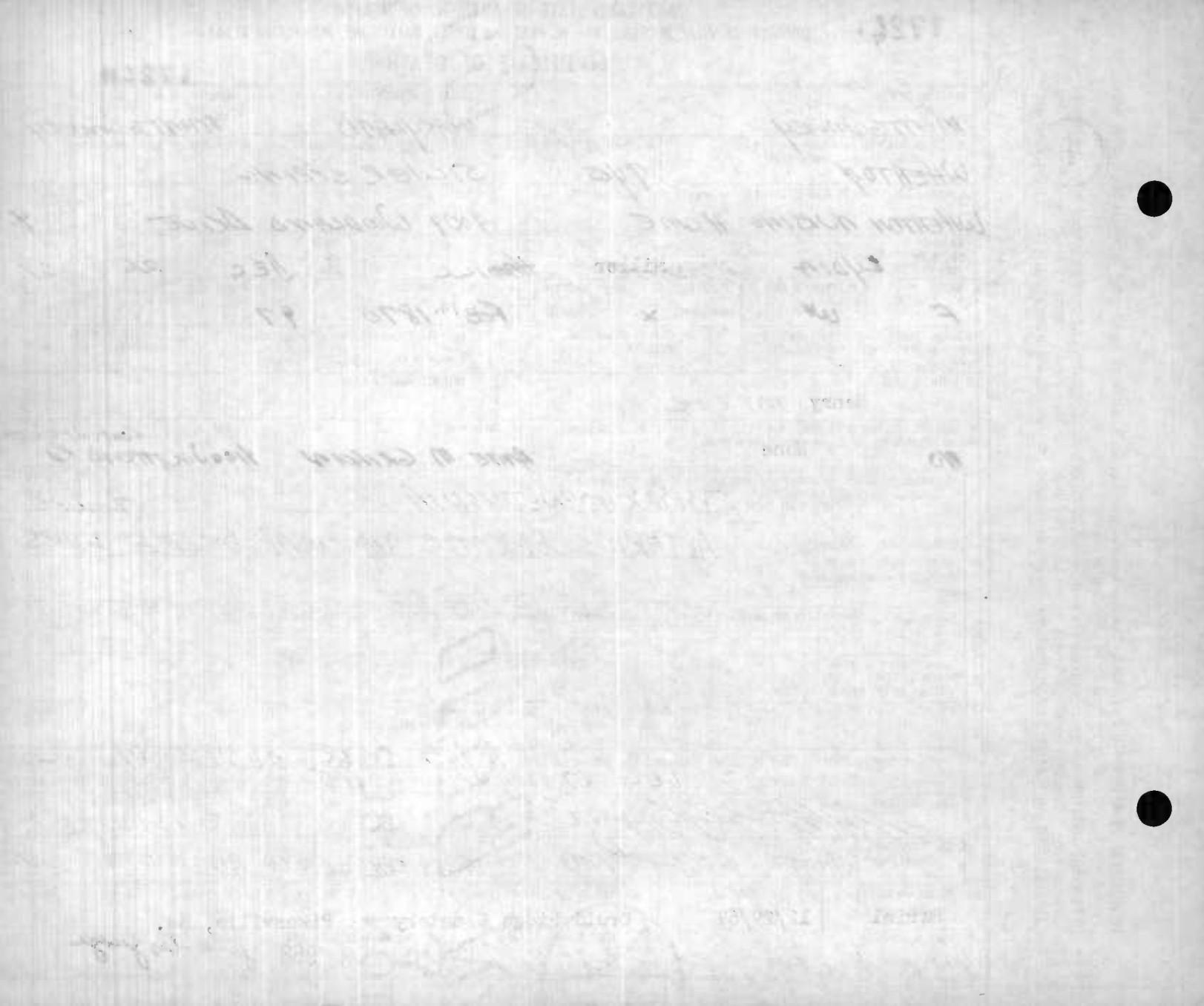
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CERTIFICATE OF DEATH

17241

17240

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WHEATON NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lydia</b>		First <b>Ric</b>	Middle <b>Miller</b>
3. NAME OF DECEASED (Type or print) <b>Lydia</b>		Last <b>Hannick</b>	4. DATE OF DEATH <b>JEC.</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>WE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		9. DATE OF BIRTH <b>Feb 14, 1870</b>	
10. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>97 yrs.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry MILLER</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Anne M. Griffin</b>		Address <b>1001 S. Cicely St., Apt. 100, SOUTHERN RD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> stating the underlying cause (c) <b>2 YRS</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>
20f. (City or town) <b>WHEATON</b>		(County) <b>MONTGOMERY</b>	
		(State) <b>MARYLAND</b>	
21. I certify that (I) (This hospital) attended the deceased from <b>10/2</b> , 19 <b>65</b> , to <b>26 DEC</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>26 DEC 19 67</b> , and that death occurred at <b>1145 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>WALTER GOOCH MD</b>		22b. DATE SIGNED <b>12/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER GOOCH MD</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>2309 SHOREFIELD RD WHEATON MD</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Druid Ridge Cemetery</b>
23d. LOCATION (City or Town) <b>Pikesville</b>		(County) <b>Md.</b>	
		(State) <b>MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Gibbons Son &amp; Sons</b>		ADDRESS <b>Baltimore, Md.</b>	25a. REC'D BY REGISTRAR <b>3 1968</b>
			25b. REGISTRAR'S SIGNATURE <b>Wm. J. Gibbons Son &amp; Sons</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

17242

CERTIFICATE OF DEATH

17241

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>420 University Blvd. W.</b>		d. STREET ADDRESS <b>420 University Blvd. W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Helen</b>		First <b>A.</b>	Middle <b>Hamilton</b>
4. DATE OF DEATH <b>December 16, 1967</b>		Month <b>December</b>	Day Year <b>16, 1967</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <b>11/3/04</b>		9. AGE (In years last birthday) <b>63 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Lechlider</b>		14. MOTHER'S MAIDEN NAME <b>Kelly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-3993</b>	
17. INFORMANT <b>James A. Hamilton, Sr. Husband same</b>		Address # <b># 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <b>metastatic carcinoma</b> DUE TO last. (c) <b>carcinoma of colon</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>obstructive hypernephroma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 11 1967</b> , to <b>Dec 11 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 11 1967</b> , and that death occurred at <b>2 PM</b> , from causes and on the date stated above.		20f. (City or town) <b>Rockville</b> (County) <b>Montgomery</b> (State) <b>Md</b>	
22a. SIGNATURE <b>J. Tyson J. Wheeler</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR J. WHEELER</b>		22d. ADDRESS <b>111 Spring St., Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/20/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1331 Rock. Pike Rockville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 21 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles J. Wheeler</b>

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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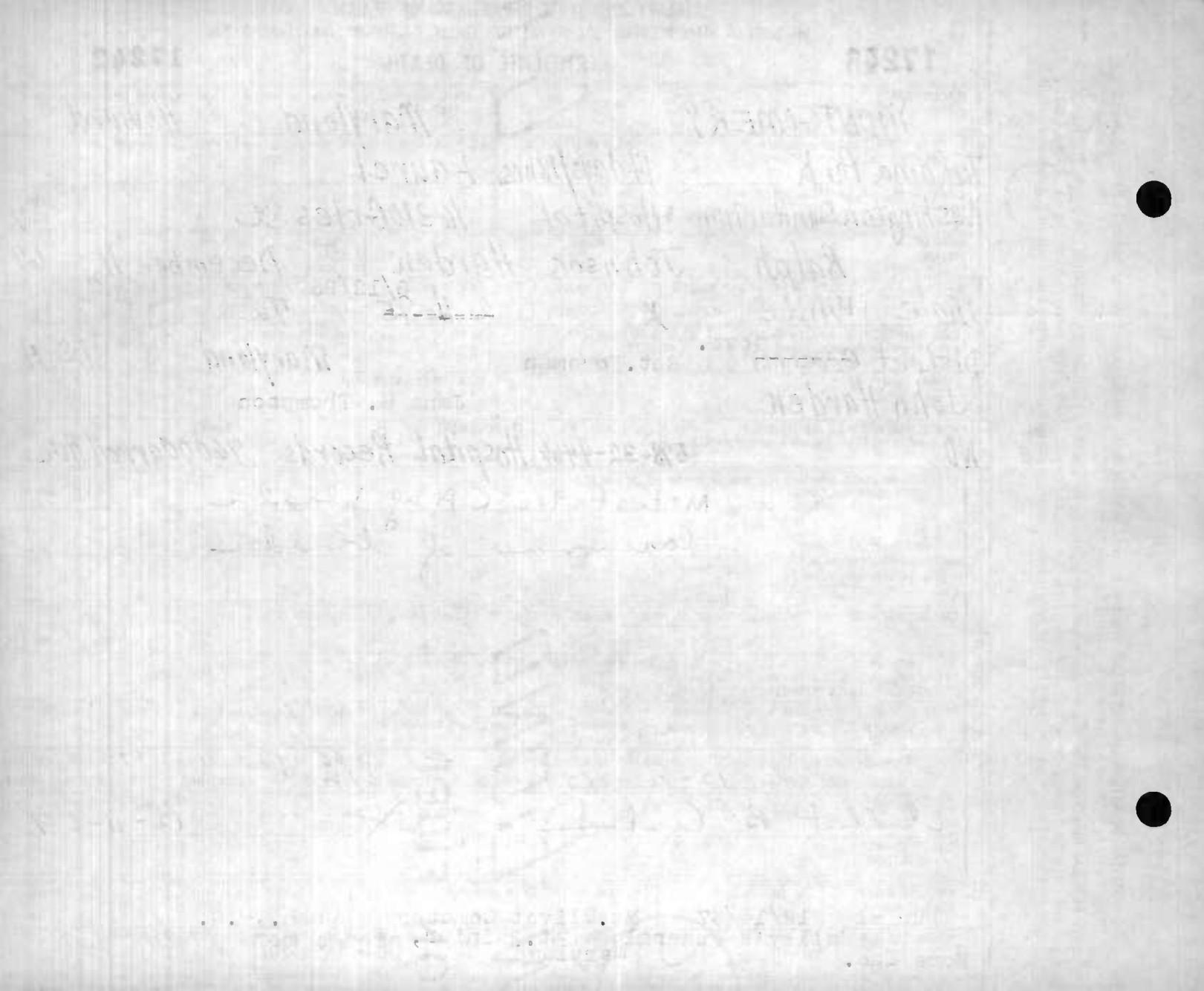
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
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CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>						c. LENGTH OF STAY IN 1b <b>14 days/18 hrs.</b>								
d. CITY OR TOWN (If not in hospital, give street address) <b>Washington Sanitarium + Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First <b>Ralph</b>	Middle <b>Johnson</b>	Last <b>Harden</b>	4. DATE OF DEATH <b>December 11, 1967</b>			Month	Day	Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-11-95</b>			9. AGE (In years birthday) <b>72 yrs.</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>District Governor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Govt. Ret. Foreman</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John Harden</b>			14. MOTHER'S MAIDEN NAME <b>Jane R. Thompson</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>578-32-4466</b>					
17. INFORMANT <b>Hospital Records</b>			Address <b>7600 Carroll Ave.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic CA of bladder</b>			INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>181.0</b>			DUE TO (b) <b>Carcinoma of bladder</b>			DUE TO (c) <b></b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Nat While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>														
21. I certify that (I) (this hospital) attended the deceased from <b>—</b> , 19 <b>66</b> , to <b>12 - 11</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>12 - 10</b> 19 <b>67</b> , and that death occurred at <b>7A M</b> , fram causes and on the date stated above.														
22a. SIGNATURE <b>Gilbert B. Ash</b>			M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>12-11-67</b>								
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/14/67</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>			23d. LOCATION (City or Town) <b>Wash., D.C.</b> (County) <b>—</b> (State) <b>—</b>					
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			ADDRESS <b>Mt. Rainier, Maryland</b>			25a. REC'D BY REGISTRAR <b>DEC 18 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



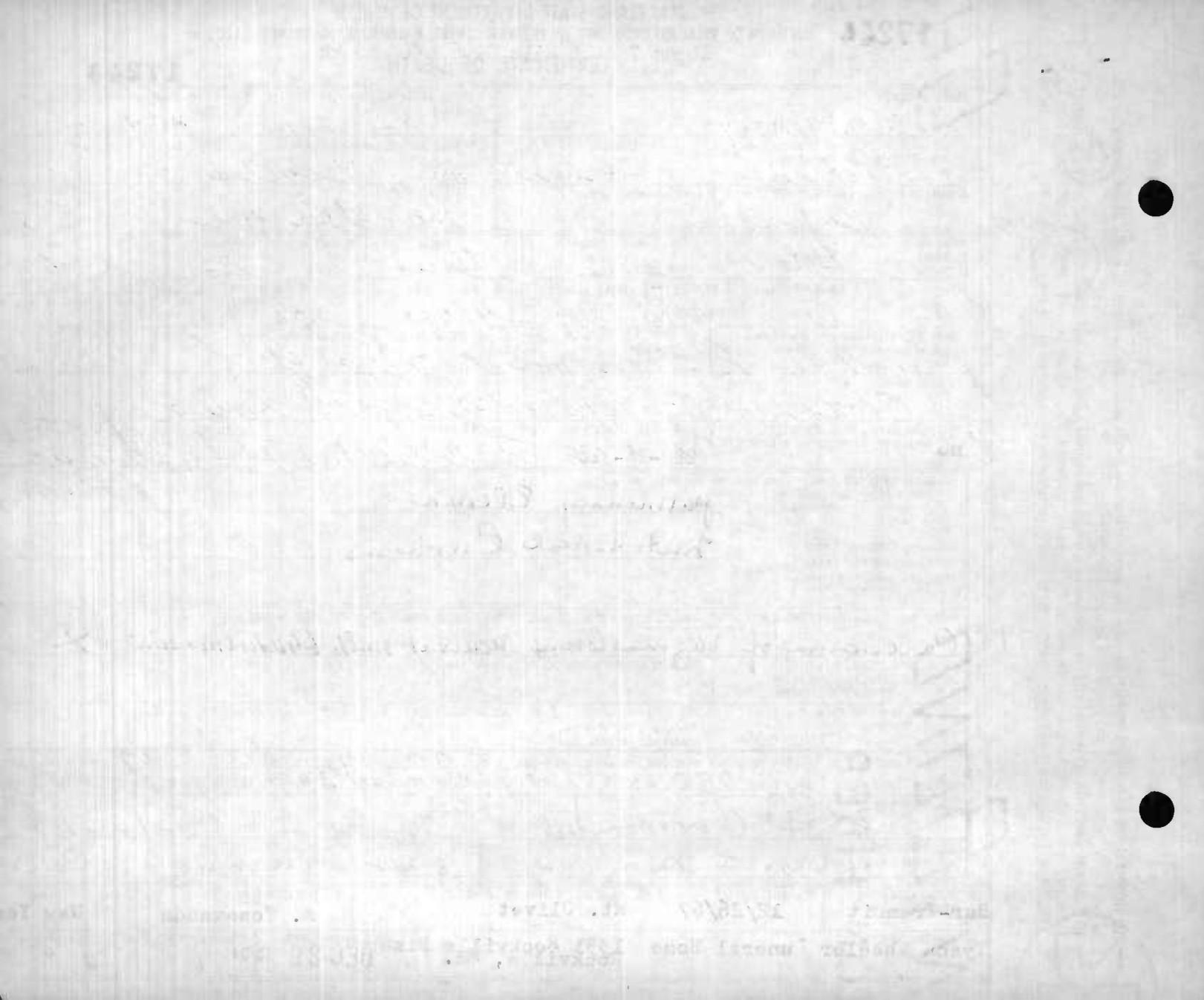
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 7 & 16 F41m G396 1/17/68 kk

17244 17243

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>24 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>4817 Chevy Chase Dr 15-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>Chevy Chase Md</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Helen</i>	Middle <i>Grene</i>	Last <i>Flare</i>	
4. DATE OF DEATH Month <i>Dec 23</i>	Year <i>1967</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>4/5/11</i>	9. AGE (In years last birthday) <i>56 yrs.</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS. Days <i>5</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Payroll Clerk Years Bookb. New York</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>ACHTERBERG MARGARET LOE NEW YORK</i>	11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles ACHTERBERG</i>	14. MOTHER'S MAIDEN NAME <i>Margaret LOE</i>	15. SOCIAL SECURITY NO. <i>220-26-7165</i>		
16. INFORMANT <i>Jane Carlson</i>	17. INFORMANT <i>Jane Carlson</i>	Address <i>313 S. 5th Street, Milwaukee, Wisconsin</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>313 S. 5th Street, Milwaukee, Wisconsin</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO <i>5810</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Nutritional Cirrhosis</i> DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of Vaginal Cervix Recurrent with Bladder Invasion</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>DESC 23 1967</i>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>JAN</i> , 19 <i>70</i> to <i>Dec</i> , 19 <i>67</i> that (II) (we) last saw the deceased alive on <i>DESC 23 1967</i> , and that death occurred at <i>1153 M.</i> from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE <i>D. Larson MD</i>		22b. DATE SIGNED <i>12/24/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>DR LARSON</i>		22d. ADDRESS <i>8218 Wisconsin Ave Bethesda</i>		
23a. BURIAL, CREMATION, Burial Transit		23b. DATE THEREOF <i>12/26/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>	23d. LOCATION (City or Town) (County) (State) <i>N. Tonawanda</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>1331 Rockville Pike Rockville, Md.</i>	25. REC'D BY REGISTRAR DATE <i>DEC 29 1967</i>	25. REGISTRAR'S SIGNATURE <i>Judge</i>



~~1~~ TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

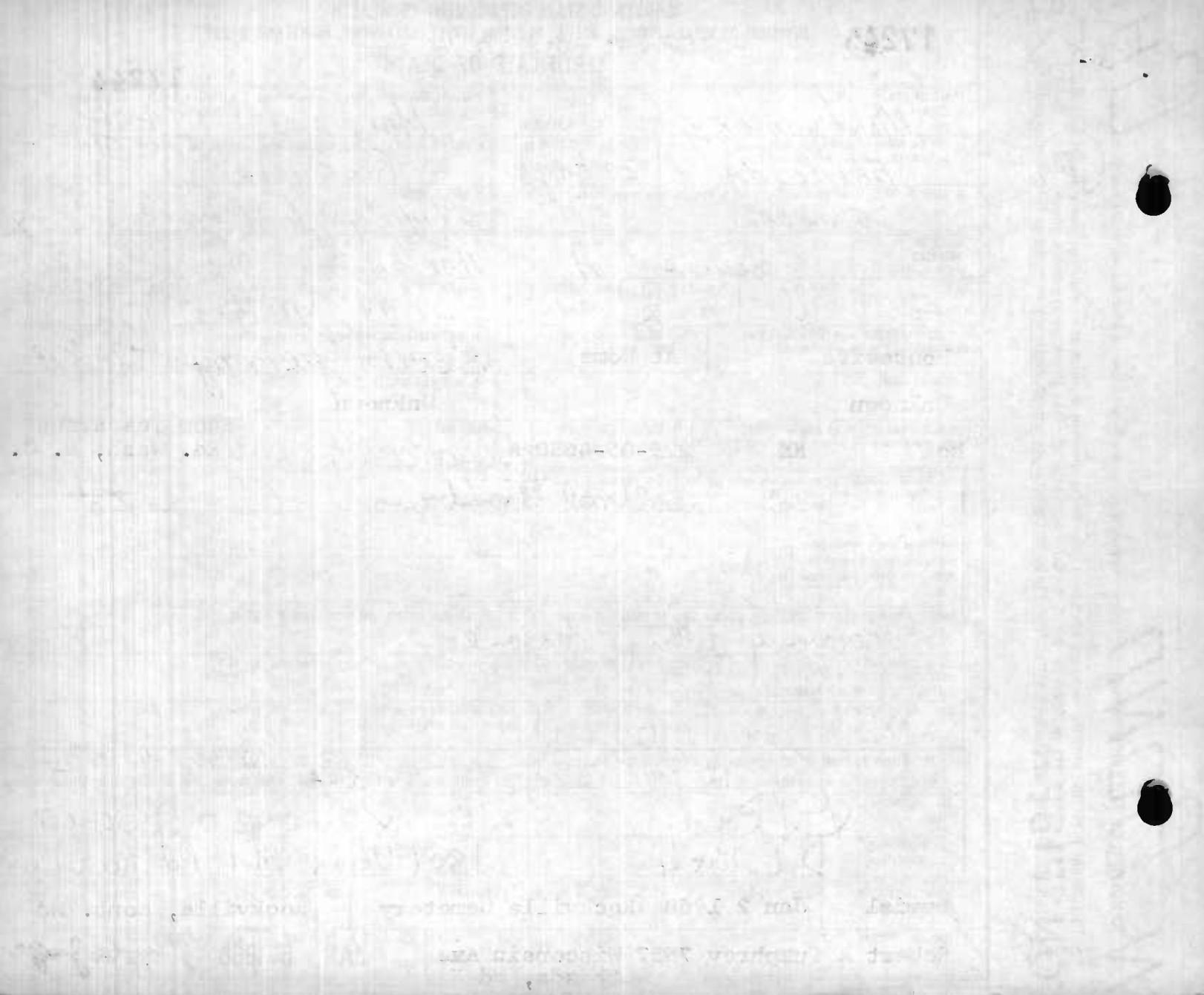
~~2~~ TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 Film G396 1/2/68 kk

CERTIFICATE OF DEATH

17244

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>22 days.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5714 Crawford Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Louisa H. Harmon</u>		First <u>Louisa</u> Middle <u>H</u> Last <u>Harmon</u>	4. DATE OF DEATH Month <u>DEC.</u> Day <u>30</u> Year <u>1967</u>
S. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) <u>92</u> 89 yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>225-05-4630</u>	17. INFORMANT <u>Daughter - L. Smith</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 d</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>coronary artery disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>Md.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>12-29</u> 1967, to <u>12-30</u> , 1967, that (I) (we) last saw the deceased alive on <u>12-29</u> 1967, and that death occurred at <u>5:10 AM</u> , from causes and on the date stated above.		22b. DATE SIGNED <u>12-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. L. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville MD</u>	
23a. BURIAL, CREMATION, <u>Burial</u>		23b. DATE THEREOF <u>Jan 2 1968</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Rockville Cemetery</u>
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>	25a. REC'D BY REGISTRAR DATE <u>JAN 5 1968</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles Juge</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

17246		17245											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>					b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>					c. LENGTH OF STAY IN 1b <b>14 days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>					d. STREET ADDRESS <b>229 Grant Avenue</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Edith</b>	Middle <b>Senora</b>	Last <b>Harper</b>	4. DATE OF DEATH		Month <b>December</b>	Doy <b>10</b>	Year <b>1967</b>	IF UNDER 1 YEAR Months <b>47 yrs.</b>	IF UNDER 24 HRS. Hours <b>151</b>	Days <b>151</b>	
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>April 7, 1920</b>	9. AGE (In years lost birthday) <b>47 yrs.</b>									
10. USUAL OCCUPATION (Give kind of work done/ during most of working life, even if retired) <b>Secretary</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>America</b>				
13. FATHER'S NAME <b>Clinton J. Pomeroy</b>			14. MOTHER'S MAIDEN NAME <b>Bessie Crump</b>			Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Patient's chart</b>							
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>540.1</b> DUE TO <b>Pulmonary congestion</b> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Pneumonia</b> ONSET AND DEATH <b>2 days</b> (c) DUE TO <b>Perforated perforated bronchial ulcer</b> <b>2 weeks</b> <b>2 weeks</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Dec 10, 1967</b> (County) <b>Dec 10, 1967</b> (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		20c. TIME OF INJURY Month, Day, Year Hour: o.m. <b>p.m.</b> <b>19</b>											
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 25th, 1967</b> to <b>Dec 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 10, 1967</b> , and that death occurred at <b>12:45 PM</b> , from causes and on the date stated above.													
22a. SIGNATURE <b>Lyle Williams</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec 10th, 1967</b>									
22c. PHYSICIAN'S NAME (Type) <b>Lyle Williams</b>		22d. ADDRESS <b>831 University Blv &amp; E. Silver Spring</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 12, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Calmar Manor</b> (County) <b>MD</b> (State)							
24. FUNERAL DIRECTOR <b>Arthur Walter, 254 Carroll St NW, DC</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							
				DATE <b>DEC 15 1967</b>									

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be returned by the hospital or attending physician.

10 Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be returned by the hospital or attending physician.

11 BURIAL-TRANSIT PERMIT: Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

17247

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

## **CERTIFICATE OF DEATH**

17246

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		b. COUNTY <b>MONT</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASH SANITARIUM + HOSPITAL</b>				d. STREET ADDRESS <b>3700 DUPONT AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>JACK</b>	Middle <b>William</b>	Last <b>HARVILLE</b>	4. DATE OF DEATH Month <b>12</b>	Month <b>8</b>	Doy <b>19</b>	Year <b>67</b>	
S. SEX <b>m</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-00</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROFREADER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>GA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JACK HARVILLE</b>				14. MOTHER'S MAIDEN NAME <b>CAROLYN BELL</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NAVY</b>		16. SOCIAL SECURITY NO. <b>578-10-2167</b>		17. INFORMANT <b>Carrie Harville Addressee</b> <b>3700 Dupont Avenue, Kensington, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>451 X</b>				INTERVAL BETWEEN ONSET AND DEATH hours <b>24 --- hrs.</b>					
IMMEDIATE CAUSE (a) <b>Shock due to</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>{</b>				DUE TO <b>(b) Rupture of abdominal aortic aneurysm</b> Years <b>24 --- hrs.</b>					
DUE TO <b>(c) Severe aortic atherosclerosis</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cirrhosis of liver</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> (CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>None</b>							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Asheville</b>		(County) <b>North Carolina</b>	(State) <b>NC</b>
21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>67</b> to <b>present</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/15/1967</b> , and that death occurred at <b>6:30 PM</b> , from causes and on the date stated above								22b. DATE SIGNED <b>12/9/67</b>	
22a. SIGNATURE <b>John B. Umhau</b>								M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <b>John B. Umhau</b>	22b. DATE SIGNED <b>12/9/67</b>
22c. PHYSICIAN'S NAME (Type) <b>John B. Umhau</b>		22d. ADDRESS <b>8805 Penn Ave. Chay Chay Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 12, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Riverside Cemetery</b>		23d. LOCATION (City or Town) <b>Asheville, North Carolina</b>		(County) <b>North Carolina</b>	(State) <b>NC</b>
24. FUNERAL DIRECTOR <b>Charles Jones Jr. Thomas Warner E. Pumphrey, Inc.</b>		ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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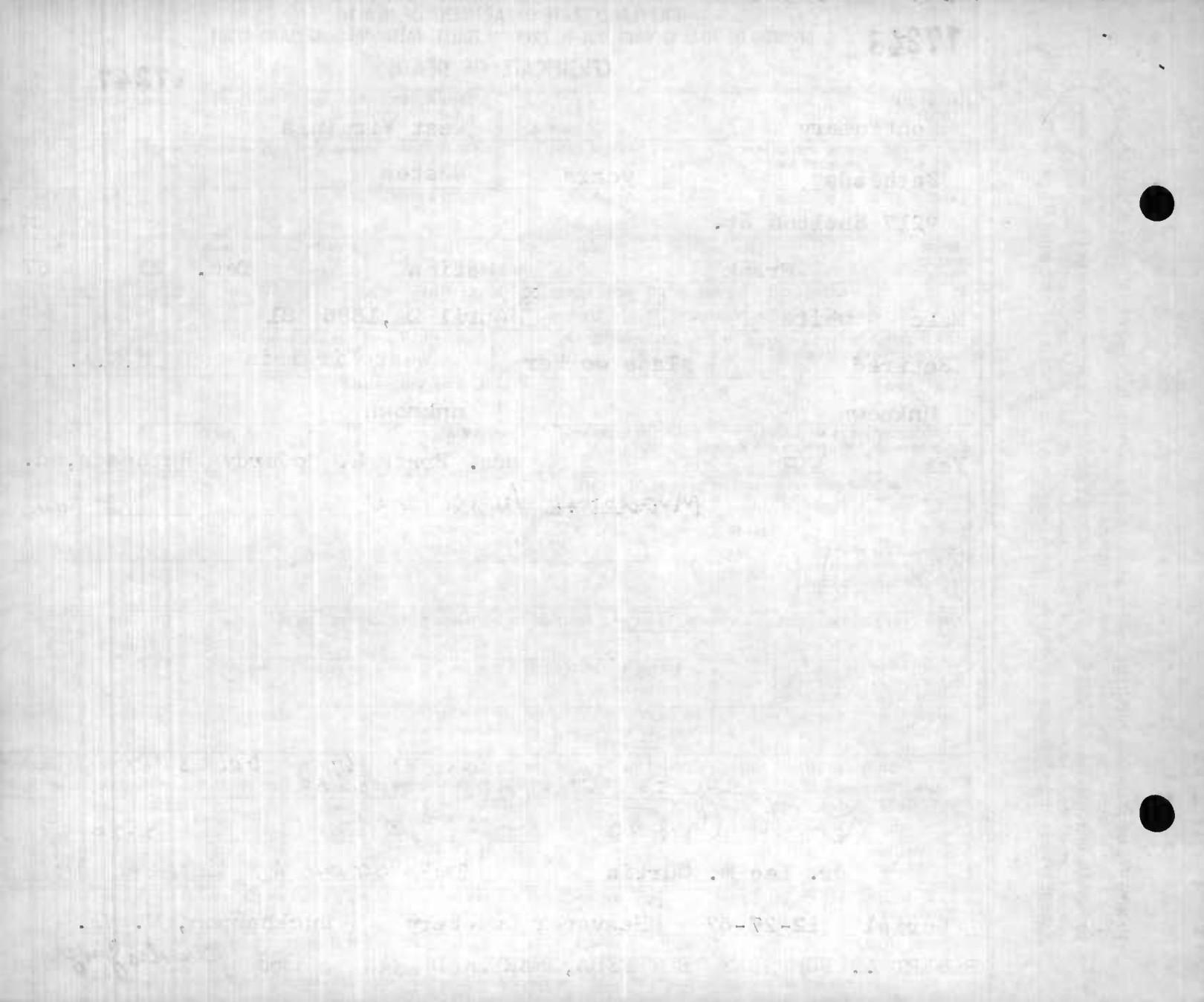
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17248		17247	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>West Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9217 Shelton St.</b>		e. STREET ADDRESS <b>Weston</b>	
<b>3. NAME OF DECEASED (Type or print)</b> <b>Frank</b>		<b>First</b> <b>Middle</b> <b>Last</b>	<b>4. DATE OF DEATH</b> <b>Dec. 23</b> <b>Month Day Year</b> <b>19 67</b>
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 2, 1886</b>
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>glass worker</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</b> <b>Yes</b> <b>WWI</b>		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Mrs. Frank H. McCurdy Bethesda, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (o)</b> <b>MYOCARDIAL INFARCTION</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4201</b> <b>15 MIN.</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20d. INJURY OCCURRED</b> <b>While</b> <input type="checkbox"/> <b>Not While</b> <input type="checkbox"/> <b>at work</b> <input type="checkbox"/> <b>20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)</b> <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>	
<b>21. I certify that (1) (this hospital) attended the deceased from</b> <b>Dec. 22, 1967</b> , to <b>Dec 23, 1967</b> , that (1) (we) last saw the deceased alive on <b>Dec. 23, 1967</b> , and that death occurred at <b>8:50 A.M.</b> from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Leo M. Curtis</b>		<b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>12-23-67</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Leo M. Curtis</b>		<b>22d. ADDRESS</b> <b>8218 WISCONSIN AVE, BETHESDA, MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12-27-67</b>	
<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <b>Heavener Cemetery</b>		<b>23d. LOCATION (City or Town)</b> <b>(County)</b> <b>(State)</b> <b>Buckhannon, W. Va.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>ROBERT A. PUMPHREY</b>		<b>ADDRESS</b> <b>BETHESDA, MARYLAND</b>	
<b>25a. REC'D BY REGISTRAR</b> <b>JAN 5 1968</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	



**1** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17249 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17248

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>a years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4016 Franklin St</u>		d. STREET ADDRESS <u>4016 Franklin St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES CLANTON HAYNES</u>		First <u>JAMES</u> Middle <u>CLANTON</u> Last <u>HAYNES</u>	4. DATE OF DEATH Dec 31 1967
S. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14 1909 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>
13. FATHER'S NAME <u>James Clanton Haynes Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Flaye Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> WW II		16. SOCIAL SECURITY NO. <u>216 40 5109</u>	17. INFORMANT <u>William Dulin</u> Address <u>5612 Grove St Ch, Ch,</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastatic Cancer to bone</u> DUE TO <u>177X</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Primary Adenocarcinoma of the Prostate</u> DUE TO <u>(b)</u> DUE TO <u>(c)</u> <u>2 1/3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>Dec 28 1967</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>4830 - 1 St. NW.</u>
20f. (City or town) <u>D.C.</u> (County) <u>D.C.</u> (State) <u>Geo Md</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 to <u>Dec 31</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec 28 1967</u> , and that death occurred at <u>8:15 A.M.</u> from causes and on the date stated above.		22b. DATE SIGNED <u>12/31/67</u>	
22a. SIGNATURE <u>Edward W. Nicklas</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS <u>4830 - 1 St. NW.</u>
22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. NICKLAS</u>		23a. BURIAL, CREMATION, REMOVAL SERVICE <u>Burial</u> 23b. DATE THEREOF <u>3 Jan. 1968</u> 23c. NAME OF CEMETERY OR CREMATORIAL <u>Ft Lincoln Cemetery</u> 23d. LOCATION (City or town) <u>Mt Rainer Pr.</u> (County) <u>Geo</u> (State) <u>Md</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>JAN 5 1968</u>	
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1932-1933

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1937-1938

1938-1939

1939-1940

1940-1941

1941-1942

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

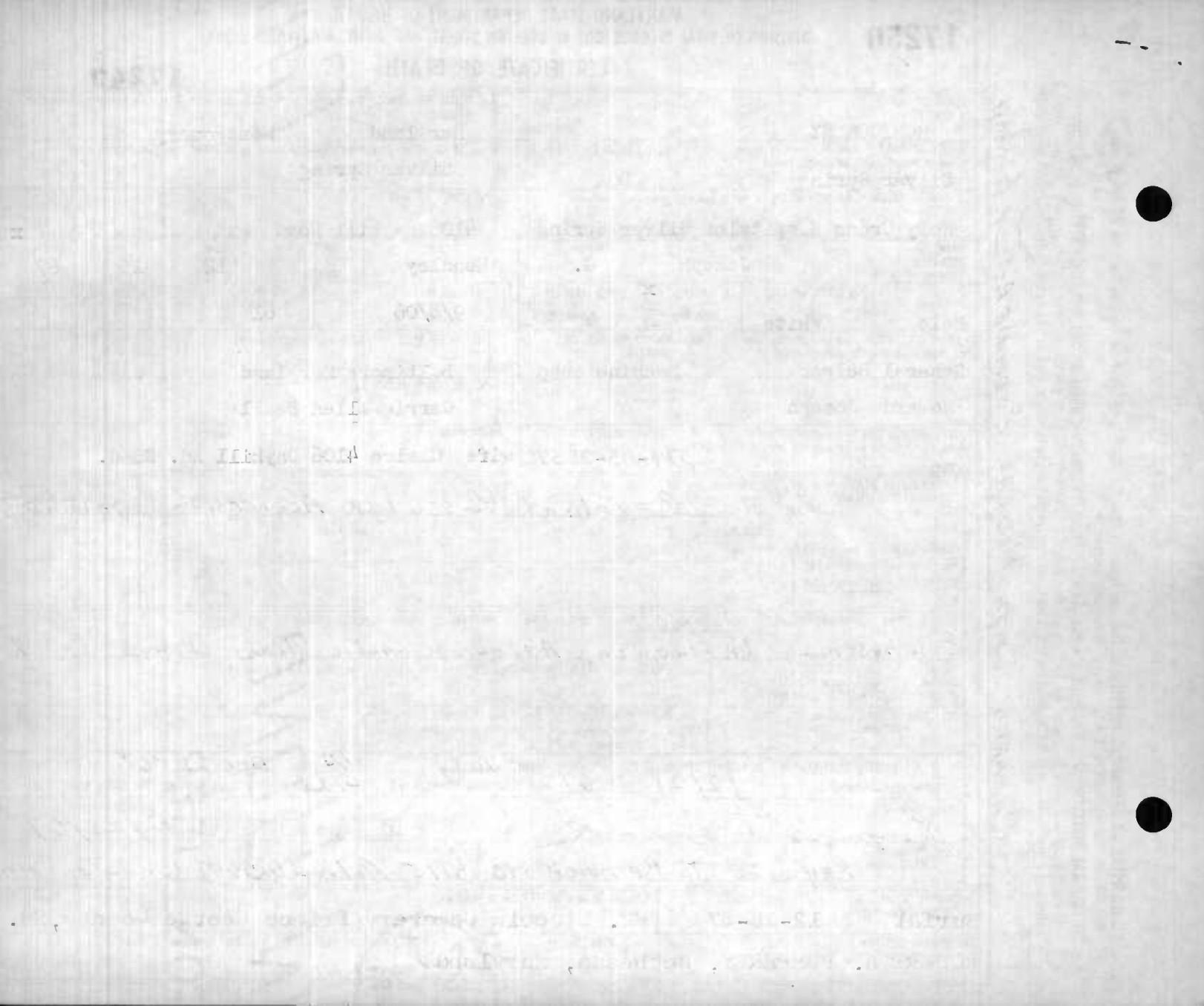
17249

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*CLEARED 2/27/67 Medical Examiner 2/27/67 Reap*

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> DOA		c. LENGTH OF STAY IN lb <b>Silver Spring</b> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital of Silver Spring</b>		e. STREET ADDRESS <b>4106 Dayhill Road</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Joseph</b>	Middle <b>G.</b>	4. DATE OF DEATH Month <b>12</b> Doy <b>25</b> Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/8/06</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machine shop</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard Joseph</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Ellen Beall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-03-2537</b>	
17. INFORMANT <b>wife Claire</b>		Address <b>4106 Dayhill Rd. SSMd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Vascular Accident</b> INTERVAL BETWEEN ONSET AND DEATH <b>MINUPS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema, Influenza, ARTERIOSCLEROTIC Heart Disease</b>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4115 Colie Drive, Wheaton MD</b>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>67</b> , to <b>Dec 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/21 1967</b> , and that death occurred at <b>Gicay</b> , from causes and on the date stated above.			
22. SIGNATURE <b>Raymond T. Benack</b>			
22c. PHYSICIAN'S NAME (Type) <b>Raymond T. Benack MD</b>		22d. ADDRESS <b>4115 Colie Drive, Wheaton MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-28-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince George County, Md.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 29 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17251		17250	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
c. LENGTH OF STAY IN lb <b>1-1/2 months</b>		d. STREET ADDRESS <b>3412 Newton Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Gertrude</b>		<b>First</b> <b>Middle</b> <b>Hernandez</b>	<b>4. DATE OF DEATH</b> <b>Dec. 4, 1967</b>
<b>S. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5/2/17</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Beautition</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b></b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Saltville, Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Albert Cahill</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Florence</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>226 10 0085</b>	
<b>17. INFORMANT</b> <b>Hospital records</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1602</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 week</b>	
(b) DUE TO		<b>20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>CARCINOMATOSIS</b> <b>CARCINOMA (MAXLARY SINUS 6 months)</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>	
<b>21. I certify that (I) (This hospital) attended the deceased from</b> <b>1935</b> , <b>19</b> , to <b>Dec. 4,</b> <b>1967</b> that (I) (we) lost saw the deceased alive on <b>Dec. 4, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.		<b>22. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>22a. SIGNATURE</b> <b>Benjamin Miller</b>		<b>22b. DATE SIGNED</b> <b>Dec. 5, 1967</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Benjamin Miller, M. D.</b>		<b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>3824 34th St., Mt. Rainier, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12-7-1967</b>	
<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Elizabeth Cemetery</b>		<b>23d. LOCATION (City or Town)</b> <b>(County)</b> <b>(State)</b> <b>Saltville, Virginia</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Nalley Funeral Home</b>		<b>25a. ADDRESS</b> <b>Mt Rainier, Md.</b>	
<b>25b. REG'D BY REGISTRAR</b> <b>DEC 7 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

17252 17251

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Althea Woodland Nsg. Home</i>			e. STREET ADDRESS <i>2832 28th St. N.W.</i>		
f. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
3. NAME OF DECEASED (Type or print)		First <i>Edna</i>	Middle <i>E.</i>	Last <i>Hickey</i>	4. DATE OF DEATH Month <i>12</i> Day <i>28</i> Year <i>1967</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-21-1882</i>	9. AGE (in years last birthday) <i>85 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (County & State, foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Elisha E. Berry</i>		14. MOTHER'S MAIDEN NAME <i>Edna Eork</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>579-60-1365</i>		17. INFORMANT <i>B. Greenley</i>	Address <i>811 Houston Takoma Park, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500</i>		<i>Chronic uremia</i> <i>1 yr.</i>			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		(b)	<i>Atherosclerotic vascular dis. gen</i> <i>5 yrs.</i>		
(c)		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>—</i>	(County) <i>—</i> (State) <i>—</i>
21. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1967</i> , to <i>Dec. 26, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec. 24, 1967</i> , and that death occurred at <i>—</i> M, from the causes and on the date stated above.					
22a. SIGNATURE <i>Thomas F. McMahon</i>					
22b. DATE SIGNED <i>12-28-67</i>					
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>3000 - Penn Ave. Wash D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>12/30/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Columbia Gardens Cem.</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>The J.W. Hines C. 2901 14<sup>th</sup> St. NW.</i>		25a. REC'D BY REGISTRAR <i>JAN 3 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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**1** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

17253 17252

1. PLACE OF DEATH <i>Montgomery County</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <i>FAIRLAND NURSING HOME</i> <i>MARYLAND</i>		a. STATE <i>MARYLAND</i> b. COUNTY <i>MONT.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRINGS</i>		c. LENGTH OF STAY IN lb <i>24.9 lbs, today</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>J.N.H.-2101 Fairland Rd. Sil. Spr., Md.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WHEATON, Md.</i>	
3. NAME OF DECEASED (Type or print) <i>Laura K. Hicks</i>		d. STREET ADDRESS <i>12008 Centerhill Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Laura K. Hicks</i>		4. DATE OF DEATH <i>DEC. 4 1967</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>Caucasian</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>15 June 1875</i>	
9. AGE (In years last birthday) <i>92 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY (RETIRED)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>TREASURY DEPT.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>OHIO</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>DEAN KIEFER</i>		14. MOTHER'S MAIDEN NAME <i>ORDELIA PRATT</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>WARREN D. HICKS - SAME AS 2A-B-C-D.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i>		<i>2 days</i>	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) <i>Coronary artery disease</i> DUE TO (c) <i>Generalized arterosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>FOSTORIA</i> (County) <i>OHIO</i> (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>8-20-65</i> , 19 <i>65</i> , to <i>12-4</i> , 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>12-4-67</i> , 19 <i>67</i> , and that death occurred at <i>57</i> M, from causes and on the date stated above		22b. DATE SIGNED <i>12-4-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Morris Perry</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>11602 Georgia Ave, Silver Spring, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12/7/1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>FOUNTAIN Mem. Cem.</i>		23d. LOCATION (City or Town) <i>FOSTORIA, OHIO</i> (County) <i>OHIO</i> (State)	
24. FUNERAL DIRECTOR <i>W.W. Chambers Inc. Silver Spring, MD</i>		ADDRESS	
		25a. REC'D BY REGISTRAR <i>DEC 7 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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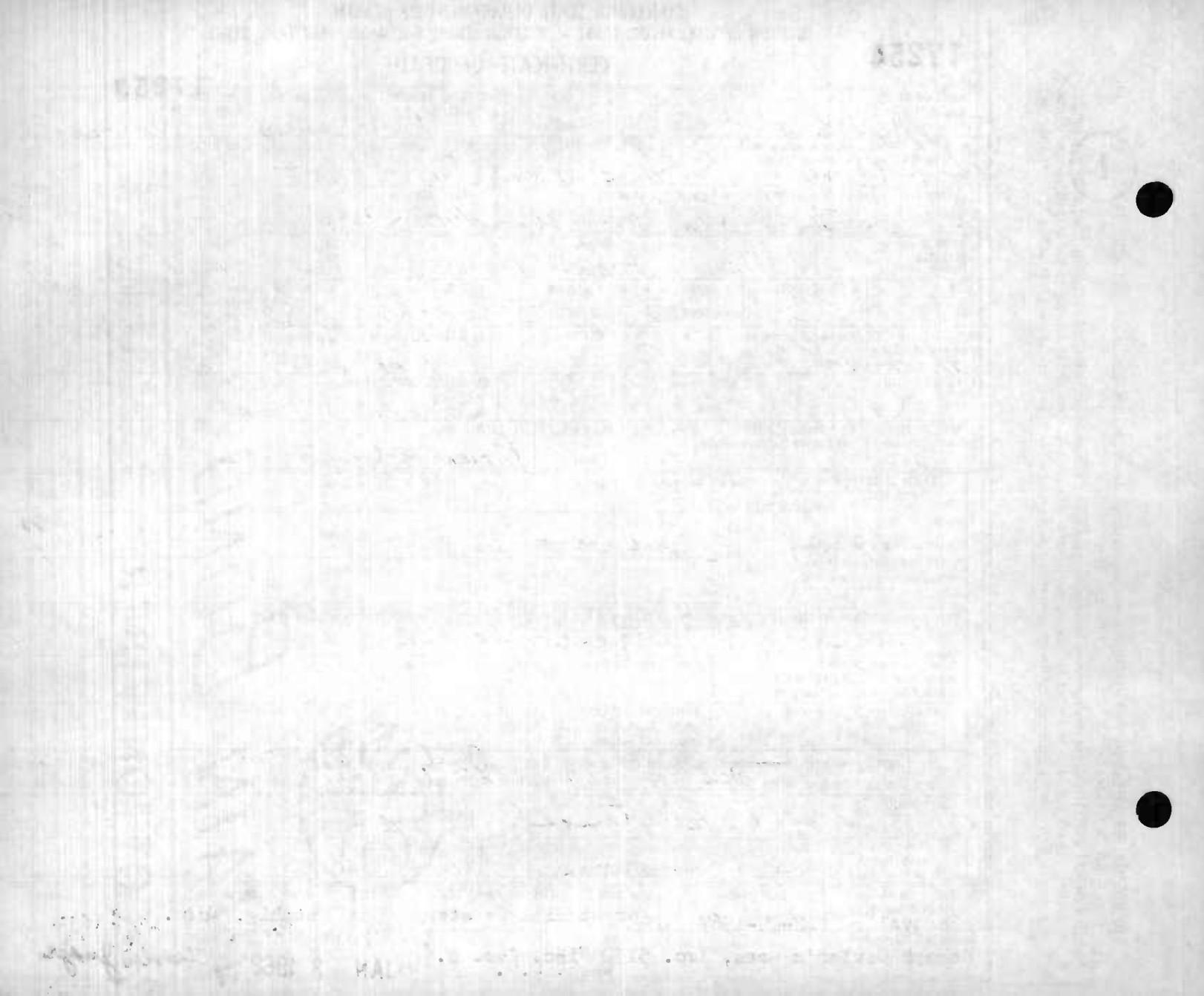
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
Montgomery Maryland		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Chevy Chase Bethesda 4 mos 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Bethesda Silver Spring Nursing Home		15-1	
4601 Drummont Ave.			
3. NAME OF DECEASED (Type or print)		First	Middle
May BAKER HIGHSAW		Lost	4. DATE OF DEATH Month Day Year 12 28 1967
S. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
FE	C		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		---	
13. FATHER'S NAME		11. BIRTHPLACE (Country & State, or foreign country) Kansas	
Moses Baker		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO. NO	
17. INFORMANT		Address PATIENT'S CHART -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
493X Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia Due to (c)		10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1967, to Dec. 28, 1967, that (I) (we) last saw the deceased alive on Dec. 28 1967, and that death occurred at 3:30 PM, from causes and on the date stated above.		22b. DATE SIGNED Dec. 28, 1967	
22a. SIGNATURE Thomas L. Hartman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Thomas L. Hartman		22d. ADDRESS 2001 I ST, N.W., WASHINGTON, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12-29-1967	
23c. NAME OF CEMETERY OR CREMATORIAL Forest Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Memphis, Tenn.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR DATE JAN 3 1968	
		25b. REGISTRAR'S SIGNATURE Charles J. George	



FOR STATE  
HEALTH DEPT.

State Department of  
Health

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film #396 MARYLAND STATE DEPARTMENT OF HEALTH  
1-4-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17255

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17254

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN lb <b>8hrs</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS <b>Washington, D.C.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ARLANDO</b>			First	Middle	Last
			<b>HILL</b>	<b>HILL</b>	<b>Month</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/6/50</b>	9. AGE (In years lost birthday) <b>17 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen helper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		
11. BIRTHPLACE (State or foreign country) <b>Wash.D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Arlando Hill, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Sallie Brown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT			Address <b>Sallie Brown-3820 8th Street, N. W.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination Hemorrhage due</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>919.6</b> { DUE TO (b) _____ DUE TO (c) and Heart.			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18). <b>Fellow employee loading revolver and it discharged bullet hitting deceased in chest.</b>		
20c. TIME OF INJURY Hour o.m. <b>12 17 19 67</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Restaurant</b>	20f. (City or town) <b>Wheaton</b>	(County) <b>Mont</b>	(State) <b>Md</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Belden R. Read</i>	EXAMINER'S NAME (Type) <b>BELDEN R. READ M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <b>Dec. 17 1967</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1/22/67</b>	23b. DATE THEREOF <b>1/22/67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Glenmont Nat.</b>	23d. LOCATION (City or Town) <b>Fl. Meyer Va</b>	(County) <b>Charles Judge</b>	(State)
24. FUNERAL DIRECTOR <b>Reliance Funeral Home</b>	ADDRESS <b>3015-12 st NE</b>	25a. REC'D BY REGISTRAR <b>DEC 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

11.000 miles

11.000 miles

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH																																				
1. PLACE OF DEATH <b>Montgomery County Maryland</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY																														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						c. LENGTH OF STAY IN lb <b>37 days.</b>																														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>																														
f. STREET ADDRESS <b>15'36 Douglas St N.E.</b>						g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																														
h. NAME OF DECEASED (Type or print)		First <b>Edward</b>	Middle <b>E</b>	Last <b>Hill</b>	4. DATE OF DEATH <b>Dec. 7 1967</b>	Month	Day	Year																												
5. SEX <b>M.</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/20/92</b>		9. AGE (in years to nearest month) <b>75 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>Seller</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Spider Ga</b>																											
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ale Hill</b>		14. MOTHER'S MAIDEN NAME <b>Lesa?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-03-4479</b>		17. INFORMANT <b>Ms. Clark</b>																										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table border="0" style="width: 100%;"> <tr> <td style="width: 15%;">PART I. DEATH WAS CAUSED BY:</td> <td colspan="3" style="width: 85%;"> <b>Failure of the Circulation</b> </td> <td style="width: 15%;">INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td>IMMEDIATE CAUSE (a)</td> <td colspan="3">DUE TO</td> <td></td> </tr> <tr> <td><b>177X</b></td> <td colspan="3"><b>Caranome of Prostate with metastases to bone of vertbrae + ribs</b></td> <td><b>6 month</b></td> </tr> <tr> <td>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</td> <td>(b)</td> <td colspan="3"></td> </tr> <tr> <td></td> <td>(c)</td> <td colspan="3"></td> </tr> </table> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												PART I. DEATH WAS CAUSED BY:	<b>Failure of the Circulation</b>			INTERVAL BETWEEN ONSET AND DEATH	IMMEDIATE CAUSE (a)	DUE TO				<b>177X</b>	<b>Caranome of Prostate with metastases to bone of vertbrae + ribs</b>			<b>6 month</b>	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	(b)					(c)			
PART I. DEATH WAS CAUSED BY:	<b>Failure of the Circulation</b>			INTERVAL BETWEEN ONSET AND DEATH																																
IMMEDIATE CAUSE (a)	DUE TO																																			
<b>177X</b>	<b>Caranome of Prostate with metastases to bone of vertbrae + ribs</b>			<b>6 month</b>																																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	(b)																																			
	(c)																																			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)																								
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 20, 1967</b> , to <b>Dec. 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 7 1967</b> , and that death occurred at <b>7:50 P.M.</b> , from causes and on the date stated above.																																				
22a. SIGNATURE <b>J. H. Mish</b>						M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED																										
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS																														
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>12/12/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Harmony Park</b>		23d. LOCATION (City or Town) <b>Fairfax</b>		(County) <b>Fairfax</b>		(State) <b>VA</b>																										
24. FUNERAL DIRECTOR		ADDRESS <b>R.N. Horton Co. 1324 14th St. NW</b>		25a. REGD. BY REGISTRAR <b>DEC 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Mish</b>		DATE																												

8351

Chilean  
Spoonbill  
Aechmophorus  
ocellatus  
Aechmophorus  
ocellatus

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**2**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 may be retained by the hospital or attending physician.  
**10** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** **12** **13** **14** **15** **16** **17** **18** **19** **20** **21** **22** **23** **24** **25** **26** **27** **28** **29** **30** **31** **32** **33** **34** **35** **36** **37** **38** **39** **40** **41** **42** **43** **44** **45** **46** **47** **48** **49** **50** **51** **52** **53** **54** **55** **56** **57** **58** **59** **60** **61** **62** **63** **64** **65** **66** **67** **68** **69** **70** **71** **72** **73** **74** **75** **76** **77** **78** **79** **80** **81** **82** **83** **84** **85** **86** **87** **88** **89** **90** **91** **92** **93** **94** **95** **96** **97** **98** **99** **100**

CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>						c. LENGTH OF STAY IN 1b <b>8hrs./55min.</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First <b>Mary</b>	Middle <b>Alexandria</b>	Last <b>Hotchkiss</b>	4. DATE OF DEATH			Month <b>December</b>	Dy <b>6</b>	Year <b>1967</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-81</b>			9. AGE (In years lost birthday) <b>86 yrs.</b>			10. IF UNDER 1 YEAR, MONTHS <b>0</b>		11. IF UNDER 24 HRS, DAYS <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Lewis Moore</b>				14. MOTHER'S MAIDEN NAME <b>Mary Becker</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>290-10-7783</b>			17. INFORMANT <b>Hospital Records</b>			Address <b>7600 Carroll Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO <b>609X</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C-RM NEC SEPSIS &amp; SHOCK</b> DUE TO <b>URINARY TRACT INECT</b> 24 hr (c) <b>URINARY TRACT INECT</b> 24 hr													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CVA with indwelling catheter</b>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>831 UNIVERSITY BLVD E.</b>		(County) <b>SILVER SPRING MD.</b>		(State)	
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>12-6-1967</b> to <b>12-6-1967</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>12-6-1967</b> , and that death occurred at <b>2551 M</b> , from causes and on the date stated above.													
22a. SIGNATURE <b>J.H. Ford</b>													
22c. PHYSICIAN'S NAME (Type) <b>JOHN L. FORD</b>				22b. DATE SIGNED <b>12/16/67</b>									
23a. BURIAL, CREMATION, REMOVALS SPECIFIED <b>CREMATION</b>				23b. DATE THEREOF <b>12/17/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>FORT LINCOLN CEM.</b>		23d. LOCATION (City or Town) <b>College Park, Maryland</b>		(County) <b>Prince George's Co. MD.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>W. W. Chambers &amp; Son Funeral Home</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 11 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

新嘉坡

新嘉坡



**1** **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

17258

**CERTIFICATE OF DEATH**

17257

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>47 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>615 Hollywood Street</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>615 Hollywood Street</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Alfred</i>		First	Middle	Lost	4. DATE OF DEATH Month <i>December</i>	Doy <i>21</i>	Year <i>1967</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>23 June 1885</i>	9. AGE (In years lost birthday) <i>82 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Metal Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>J.C. Flood Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Houston</i>				14. MOTHER'S MAIDEN NAME <i>Mary Keating</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes 1918-1919</i>		16. SOCIAL SECURITY NO. <i>213-58-7934</i>		17. INFORMANT <i>Silver Spring, MD Address Mrs. Blanche M. King 615-Hollywood Avenue</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Senile myocarditis</i> , INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>							
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>arteriosclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>year</i> , 19 <i>67</i> , to <i>11-20</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11-20</i> 19 <i>67</i> , and that death occurred at <i>4:45 PM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>John N. Andrews</i>		22b. DATE SIGNED <i>12-22-67</i>					
22c. PHYSICIAN'S NAME (Type) <i>John N. Andrews</i>		22d. ADDRESS <i>9601 Colesville Rd Silver Spring Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 26. 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate Of Heaven</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR <i>Clinton C. Glen Carter</i>		ADDRESS <i>Warren E. Pumphrey, Inc. 8434 Ga. Ave. Sil Spgs. Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Jagger</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jagger</i>	
VR A15 (4) 20 M 1/66				DATE <i>DEC 28 1967</i>			

10. Under the heading "Other Information," state whether or not the firm has been involved in any other type of business during the past year.

11. Under the heading "Other Information," state whether or not the firm has been involved in any other type of business during the past year.

12. Under the heading "Other Information," state whether or not the firm has been involved in any other type of business during the past year.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

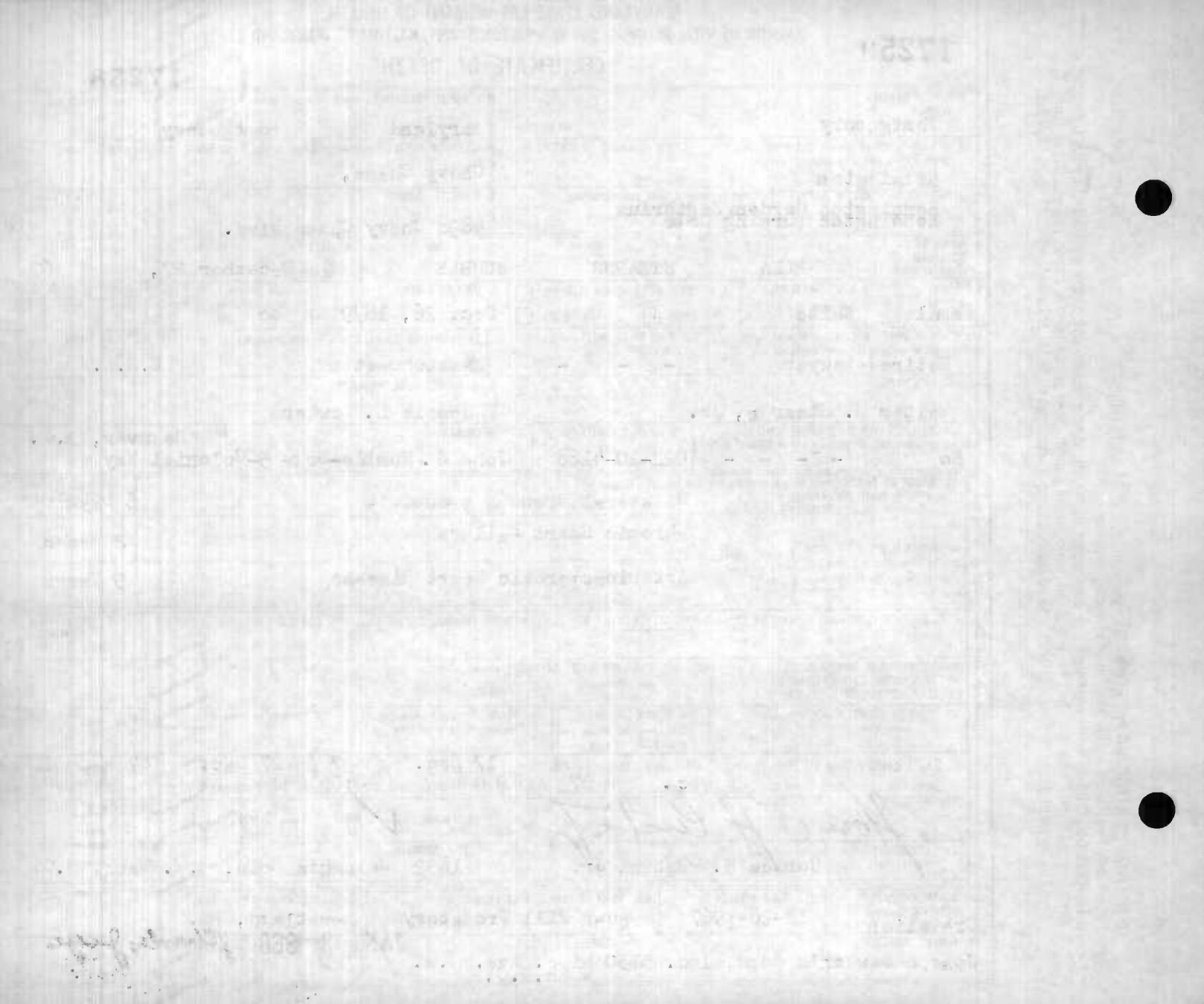
**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4  
25M 1/6)

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN lb		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Garden Santorium Kensington Nursing Home</b>				d. STREET ADDRESS <b>4898 Chevy Chase Blvd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>ELLA</b>	Middle <b>STEARNS</b>	Last <b>HUMBLE</b>	4. DATE OF DEATH <b>December 27,</b>	Month <b>1967</b>	Day Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <b>Dec. 26, 1879</b>	9. AGE (In years less birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter H. Stearns, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Jessie L. Bowker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>022-20-4168</b>		17. INFORMANT <b>John S. Humble-Son</b>		Address <b>Hanover, N.J.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>{</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
DUE TO <b>Bilateral Broncho pneumonia</b>				2 Weeks			
(b) DUE TO <b>Chronic Heart Failure</b>				5 Years			
(c) DUE TO <b>Arteriosclerotic Heart Disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>17 Dec.</b> , 1967, to <b>27 Dec.</b> , 1967, that (I) (we) last saw the deceased alive on <b>26 Dec.</b> , 1967, and that death occurred at <b>8:05 M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Horace H. Custis</b>				22b. DATE SIGNED <b>1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Horace H. Custis, Jr.</b>		22d. ADDRESS <b>1852 Columbia Road, N.W. Wash. D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12-28-1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland, Md.</b> (County) (State)	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>		25a. BY REGISTRATION <b>JAN 8 1968</b>		25b. REGISTRATION NO. <b>Horace H. Custis</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DERT.

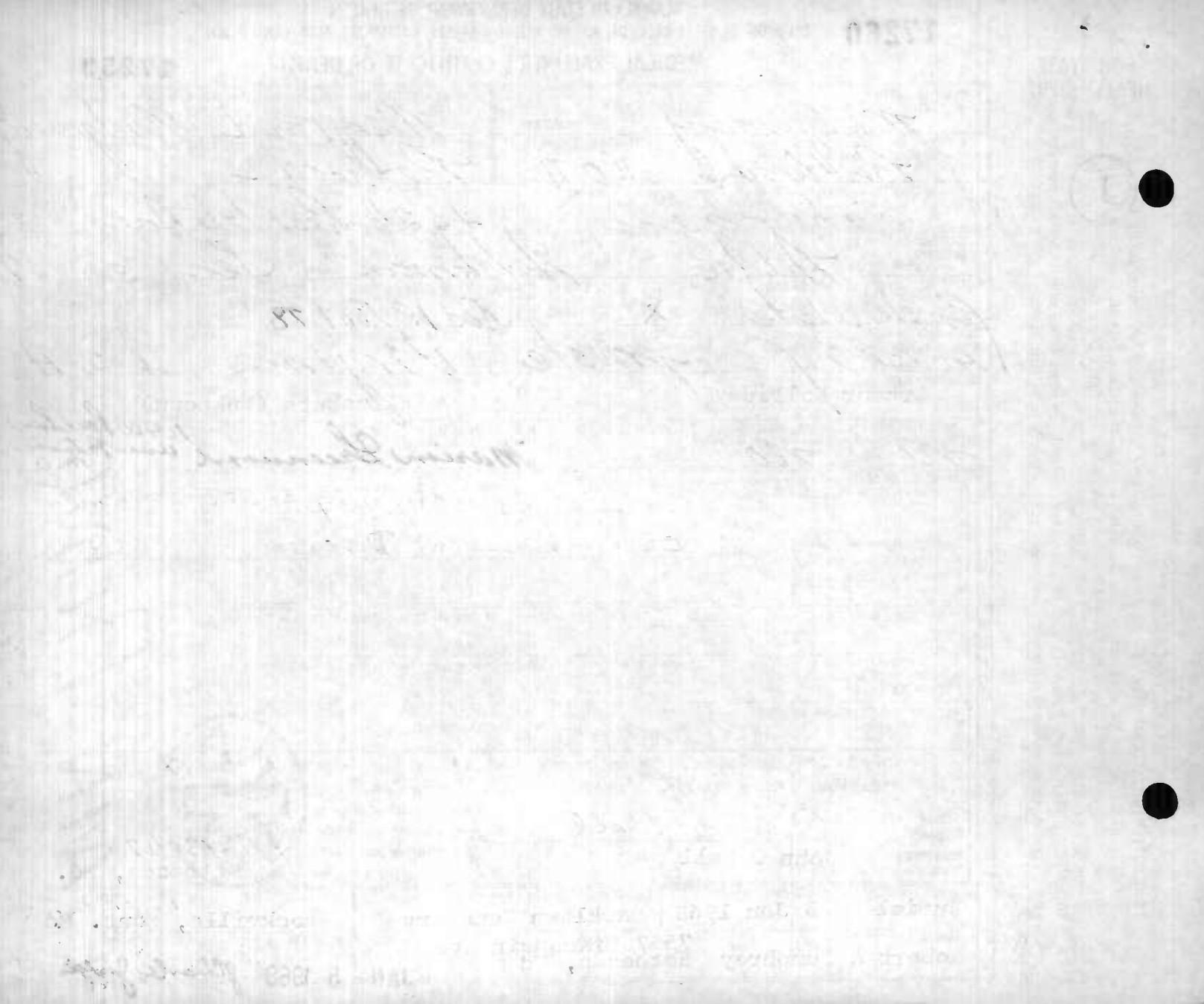
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 17259, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17260

17259

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>404</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Tuberculosis</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Addie</i>	Middle <i>Hutchinson</i>	4. DATE OF DEATH <i>Dec. 30 1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> <i>Divorced</i>	8. DATE OF BIRTH <i>Dec 18 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Arthur Holliday</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth (Unknown)</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>700</i>		17. INFORMANT <i>Mariam Greenwood</i>	Address <i>10400 Rockhouse Lane Bethesda MD</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>  <i>Coronary Insufficiency Acute - Cardio Vascular Disease.</i> <i>Years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>(City or town) (County) (State)</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>John G Ball</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, Burial <input checked="" type="checkbox"/>	23b. DATE THEREOF <i>3 Jan 1968</i>	23c. NAME OF CEMETERY OR CREMATORIALy <i>Parklawn Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Mont. Md</i>
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>	7557 Wisconsin Ave Bethesda, Md	25a. REC'D BY REGISTRAR <i>JAN 5 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17261

17260

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH	2b. HOUR			
<i>ELIZABETH (NMN) INCHES</i>							12 Month 24 Day 67 Year	3:40A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS		
<i>FEMALE</i>		<i>white</i>		<i>SEPT 11, 1886</i>		<i>81 yrs.</i>		MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WOOOWEO <input checked="" type="checkbox"/> DIVORCEO <input type="checkbox"/>		9. COUNTY OF DEATH					
<i>Canada</i>		<i>U.S.</i>				<i>Montgomery</i>		<i>Montgomery</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
<i>Kensington</i>		<i>Carroll Hall San</i>				<i>Housewife</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
<i>Md.</i>		<i>Montgomery</i>		<i>Gaithersburg</i>		<i>YES</i>		<i>unknown</i>			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
<i>Richard</i>		<i>T</i>		<i>Evans</i>	<i>Elizabeth</i>				<i>McAvish</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
<i>No</i>		<i>577-34-1202</i>		<i>Robert Innes</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>											
4201 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerotic heart disease</i> —											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <i>Generalized Arteriosclerosis</i> —											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>SEPT 26, 1966</i> , to <i>DECEMBER 24 1967</i> , that (I) (we) lost saw the deceased alive on <i>DECEMBER 24 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		<i>Henry M. Lowden MD</i>				DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12-24-67</i>	
22d. PHYSICIAN'S NAME (Type)		<i>Henry M. Lowden</i>				22e. ADDRESS <i>5206 Normandy Dr. Cherry Chase Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Dec. 28 1967</i>		23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) <i>Laytonsville</i>		(County) <i>Mont.</i>		(State) <i>Md.</i>	
Burial											
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<i>Francis H. Barber</i>		<i>Laytonsville Md</i>				<i>JAN 2 1968</i>		<i>Funerals Judge</i>			
BB											

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10 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17262 CERTIFICATE OF DEATH 17261

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda MD</i>		c. LENGTH OF STAY IN 1b <i>7 days.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>The suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
3. NAME OF DECEASED (Type or print) <i>Edwin Warley James</i>		First <i>E</i>	Middle <i>d</i>
3. NAME OF DECEASED (Type or print) <i>Edwin Warley James</i>		Last <i>James</i>	4. DATE OF DEATH <i>Dec. 22 1967</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct. 17 1877</i>		9. AGE (In years last birthday) <i>90 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Public works</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edwin James</i>		14. MOTHER'S MAIDEN NAME <i>Edna Warley</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>879-44-6038</i>	
17. INFORMANT <i>George Ann Clark</i>		Address <i>Alice James, 52nd Avenue</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO <i>5702</i>		INTERVAL BETWEEN ONSET AND DEATH <i>long time</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Int. Obstruction</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Dec 22 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Office</i>
20f. (City or town) <i>Dec 22 1967</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>Dec 22, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 12 1967</i> , and that death occurred at <i>6:50 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Stewart Clapp</i>		22b. DATE SIGNED <i>Dec 22 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Stewart Clapp M.D.</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>27740 Chevy Chase Drive Chevy Chase MD 20815</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>Dec 24, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>
24. FUNERAL DIRECTOR <i>Joseph Gawley's Sons Inc. WASH, D.C.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>JAN 3 1968</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles J. G</i>

COAST



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17263		<b>CERTIFICATE OF DEATH</b>										17262	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>67 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7109 Fairly Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>Gladys</u>	Middle <u>P.</u>	Last <u>Jenkins</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1967</u>								
5. SEX <u>F</u> white		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/16/85</u>		9. AGE (In years lost birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		Months		Days Hours Min.			
13. FATHER'S NAME <u>Gideon Samuel Palmer</u>		14. MOTHER'S MARRIED NAME <u>Mary Laura O'Neill</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-1177</u>		17. INFORMANT <u>Susan J. Hale</u>		Address <u>39 Van Ave Pittsburgh, Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> Myocardial Decamp. with Pulmonary edema. INTERVAL BETWEEN ONSET AND DEATH <u>37 days</u> . DUE TO (b) <u>Uremia, terminal, severe</u> <u>2 months</u> . DUE TO (c) <u>Arteriosclerosis, generalised.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Bronx</u>		(County) <u>New York</u>		(State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 12-7-1967, that (I) (we) last saw the deceased alive on 12-7-1967, and that death occurred at 7:55 P.M. from causes and on the date stated above.		22b. DATE SIGNED <u>12-7-67</u>											
22a. SIGNATURE <u>Stewart Clapp M.D.</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS <u>4740 Chevy Chase Dr Chevy Chase Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-11-67</u>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Hoodlawn Cemetery</u>		23d. LOCATION (City or Town) <u>Bronx</u>		(County) <u>New York</u>		(State)			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

beginning in month  
middle years  
and about 1912  
will consist of rapidly  
increasing & short  
and very well  
defined and well defined  
with most marked and well  
defined dark Pseudomorphs.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

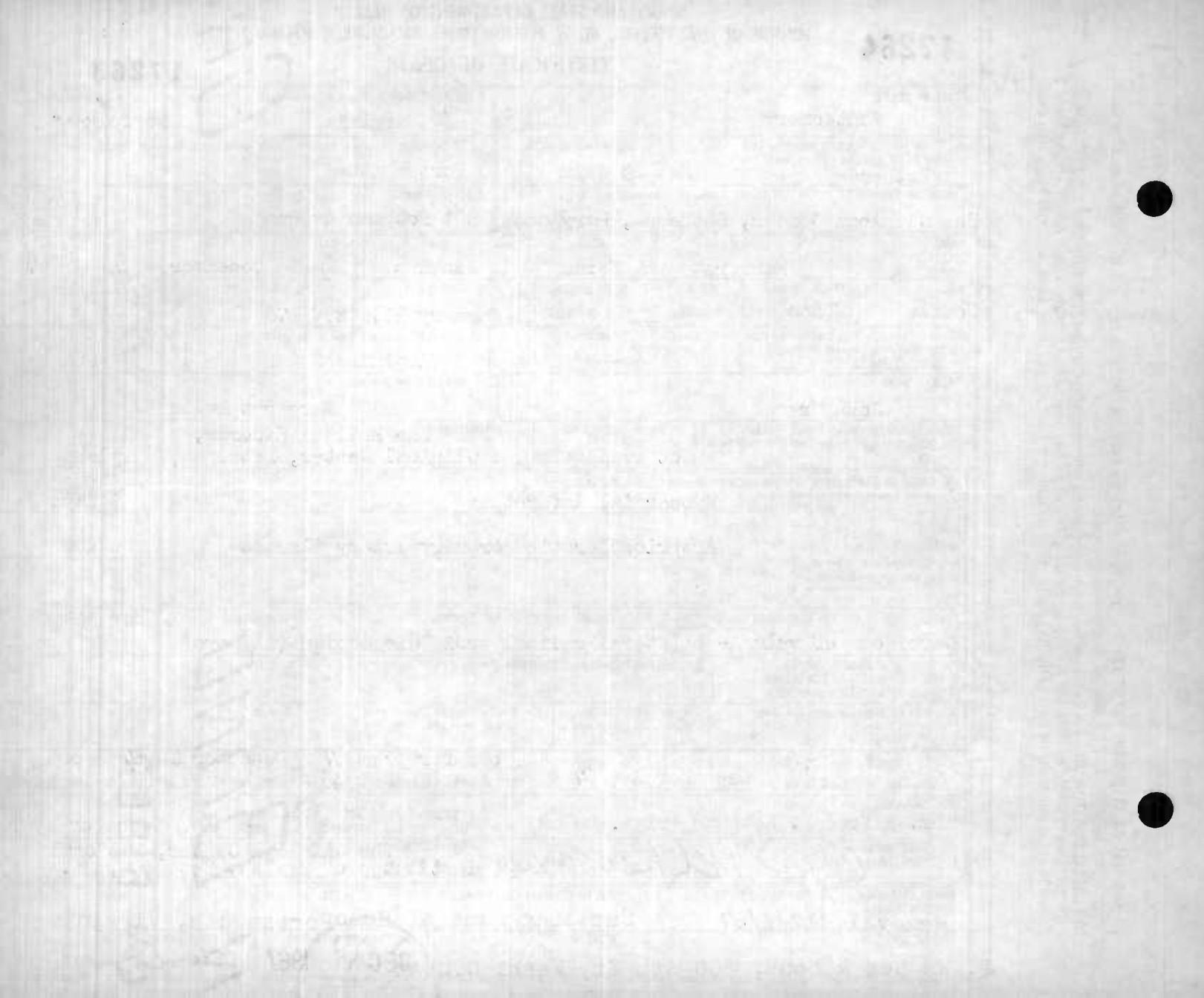
CERTIFICATE OF DEATH

17263

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b>		b. COUNTY <b>Norfolk</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>23 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Portsmouth</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>801 Potomac Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Margaret</b>		First <b>Margaret</b>	Middle <b>Sarah</b>	Last <b>Jenkins</b>	4. DATE OF DEATH <b>December 4 1967</b>	Month <b>December</b>	Day <b>4</b>	Year <b>1967</b>			
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 31, 1891</b>	9. AGE (In years lost birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>John Green</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Kellum</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>Not available</b>		17. INFORMANT The Medical Records, <sup>Address</sup> The Clinical Center, Bethesda, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>					
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic coronary artery disease</b>		DUE TO (b) <b>Arteriosclerotic coronary artery disease</b>				Unknown					
		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma of vulva - bilateral radical groin dissection (11 days)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While at work</b>		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Snelling Funeral Home</b>		20f. (City or town) (County) (State) <b>Portsmouth, Virginia</b>	
21. I certify that <b>Dr. Alfred S. Ketcham</b> attended the deceased from <b>November 11, 1967</b> , to <b>December 4 1967</b> , that <b>we</b> last saw the deceased alive on <b>December 4 1967</b> , and that death occurred at <b>6:45 M</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>Dr. Alfred S. Ketcham (Sign. below)</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		MED. STAFF PHYS. <input checked="" type="checkbox"/>		AM <input type="checkbox"/> 4 December 1967		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Alfred S. Ketcham MD</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12/4/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Snelling Funeral Home</b>		23d. LOCATION (City or Town) (County) (State) <b>Portsmouth, Virginia</b>					
24. FUNERAL DIRECTOR <b>J. Wm Lee &amp; Sons, 300 4th St, Wash, D.C.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health.

<b>CERTIFICATE OF DEATH</b>															
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montg.</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN lb <b>1 yr 8 mo 19 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SHARON Nsg Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Minnie Olive Johnson</b>				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/14/1867</b>				9. AGE (In years last birthday) <b>100 yrs.</b>			10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 1 Year Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Richmond, Ind.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Lane Perry</b>				14. MOTHER'S MAIDEN NAME <b>Lucinda Bradley</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-54-12417</b>				17. INFORMANT <b>Leslie E. Johnson</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brechro pneu mura</b> DUE TO <b>Fracture</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Sensitivity</b>				(b) <b>Fracture</b>				(c) <b>Pt hump</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture Pt hump</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fracture Pt hump</b>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Nsg Home</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Fracture Pt hump</b>				20f. (City or town) <b>Fracture Pt hump</b> (County) <b>Fracture Pt hump</b> (State) <b>Fracture Pt hump</b>			
21. I certify that (I) (this <b>Hospital</b> ) attended the deceased from <b>4/22</b> , 19 <b>66</b> to <b>12/3</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>12/3/1967</b> , and that death occurred at <b>3pm</b> M, from causes and on the date stated above.															
22a. SIGNATURE <b>Olive Johnson</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>12/3/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>C.H. Ligon MD</b>				22d. ADDRESS <b>JANET SPRING, MD.</b>				23d. LOCATION (City, State) <b>Fracture Pt hump, Kansas</b> (County) <b>Fracture Pt hump, Kansas</b> (State) <b>Fracture Pt hump, Kansas</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12/9/67</b>				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Tarnow Cemetery</b>				23d. LOCATION (City, State) <b>Fracture Pt hump, Kansas</b> (County) <b>Fracture Pt hump, Kansas</b> (State) <b>Fracture Pt hump, Kansas</b>			
24. FUNERAL DIRECTOR <b>Robert Pumphrey Funeral Home, Rockville, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

4331

11A30-39 11A31-39

11A30 11A31

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

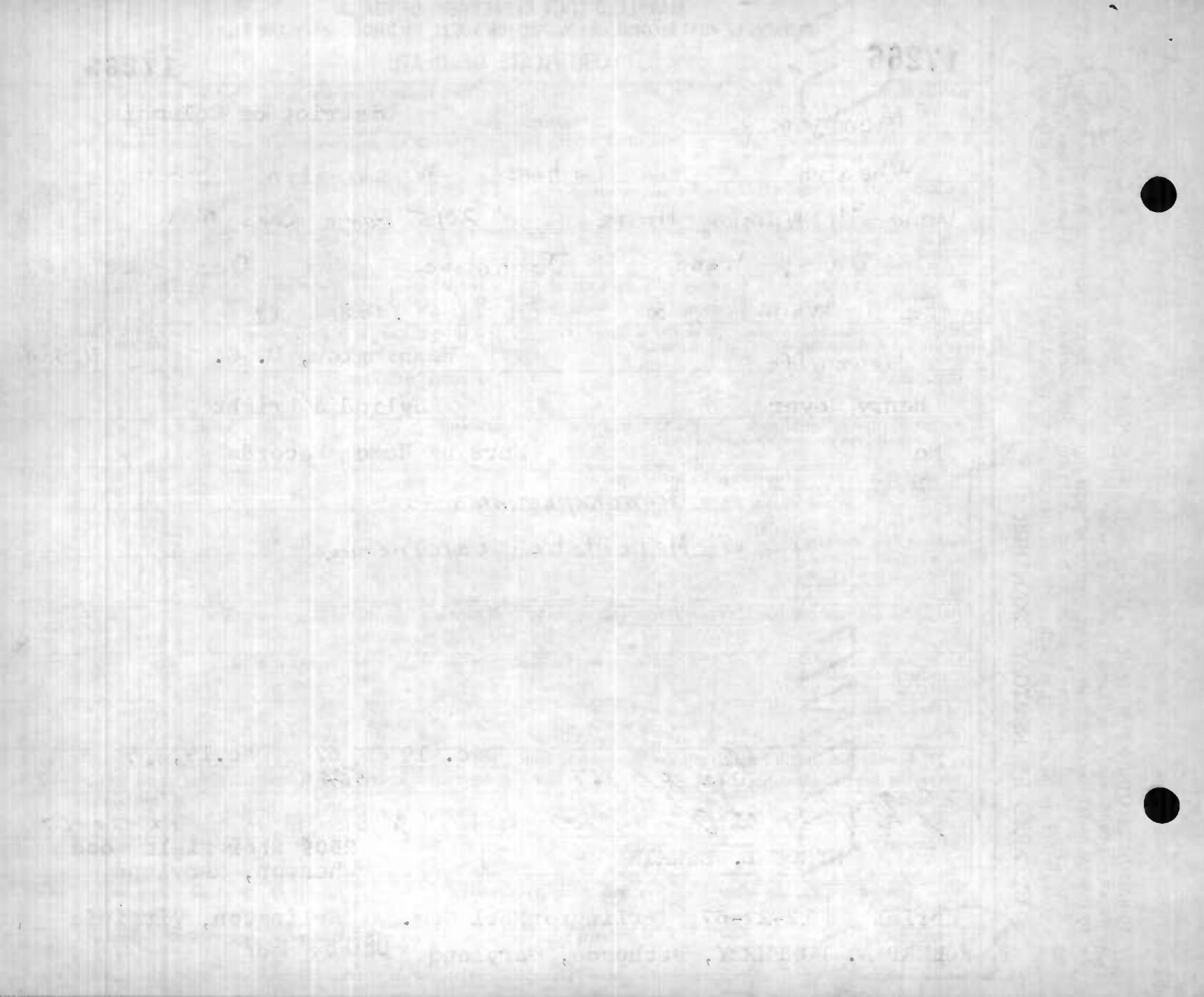
CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED BY MEDICAL EXAMINER

17266		17265	
<p>1. PLACE OF DEATH            a. COUNTY <b>Montgomery</b>            MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b></p> <p>c. LENGTH OF STAY IN 1b <b>16 hours</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)            a. STATE <b>District of Columbia</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b></p> <p>d. STREET ADDRESS <b>2015 Park Road N.W.</b></p> <p>e. IS RESIDENCE ON A FARM?            YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED            First <b>Daisy</b> Middle <b>Irene</b> Last <b>Johnstone</b></p> <p>4. DATE OF DEATH <b>Dec. 20 1967</b></p> <p>5. SEX <b>F</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>            WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <b>9/28/1880</b> 9. AGE (In years lost birthday) <b>87 yrs.</b></p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Washington, D.C.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>Henry Boyer</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Sylindia Bright</b></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT <b>Nursing Home Records</b></p>		<p>Address</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <b>1992</b> DUE TO <b>Bronchopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Metastatic carcinoma</b></p> <p>(c)</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year            Hour o.m. <b>p.m.</b> <b>19</b></p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>
<p>20f. (City or town) <b>Dec. 19, 1967</b> (County) <b>Dec. 19, 1967</b> (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 19, 1967</b> to <b>Dec. 19, 1967</b>, that (I) (we) last saw the deceased alive on <b>Dec. 20, 1967</b>, and that death occurred at <b>5:00 A.M.</b> from causes and on the date stated above.</p>			
<p>22a. SIGNATURE <b>Myron L. Lenkin</b></p>		<p>22b. DATE SIGNED <b>12-20-67</b></p>	
<p>22c. PHYSICIAN'S NAME (Type) <b>MYRON L. LENKIN</b></p>		<p>22d. ADDRESS <b>2500 Shorefield Road Wheaton, Maryland</b></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>23b. DATE THEREOF <b>12-22-67</b> 23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Natl Cem.</b></p>	
<p>24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b></p>		<p>ADDRESS <b>250. REC'D BY REGISTRAR <b>DEC 26 1967</b></b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>	
		<p>DATE</p>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

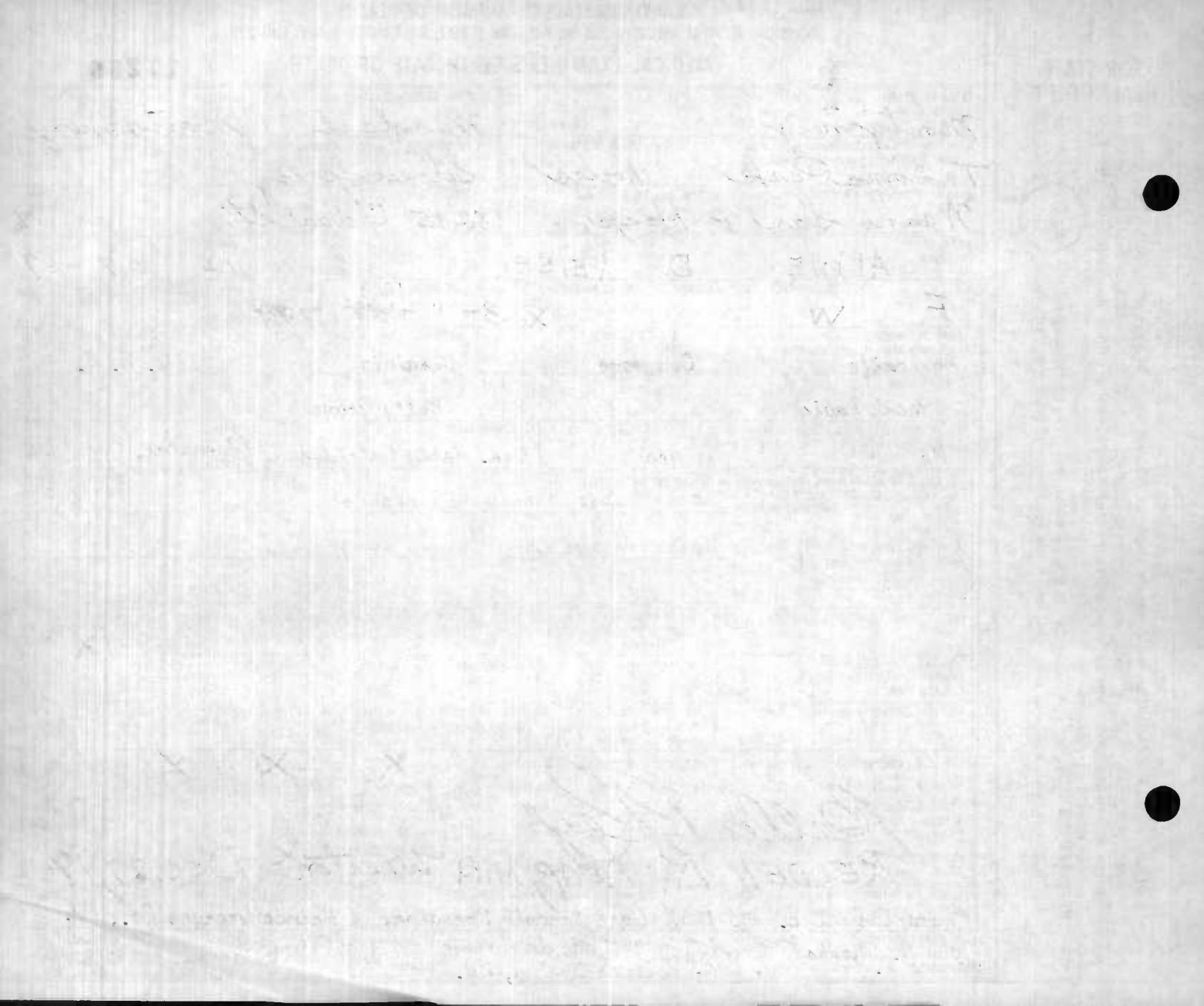
17266

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**NO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>8215 Cedar St.</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. Sant + Hosps.</i>				d. STREET ADDRESS <i>15-1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>ALINE</i>		First <i>D.</i>	Middle <i>KEISER</i>	Last	4. DATE OF DEATH <i>12 27 1967</i>	Month	Day	Year		
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>1889</i>	9. AGE (In years last birthday) <i>78 77 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
13. FATHER'S NAME <i>Frank Davis</i>				14. MOTHER'S MAIDEN NAME <i>Betty Grove</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Mrs. Betty Gutridge</i>		Address <i>Edgewater, Maryland</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		Acute Subarachnoid Hemorrhage								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Hypertensive Cardiovascular Disease								
		DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED <i>DEC. 27 1967</i>
ACTUAL SIGNATURE <i>Belden R. Peap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.								
EXAMINER'S NAME (Type) <i>BELDEN R. PEAP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Prince Georges Co., Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Dec. 20, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md.</i>				
24. FUNERAL DIRECTOR <i>John B. Thomas</i>		ADDRESS <i>8434 Georgia Avenue</i>		25e. REC'D BY REGISTRAR DATE <i>JAN 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
Warren E. Donnelly, Inc.		Silver Spring, Md.								



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

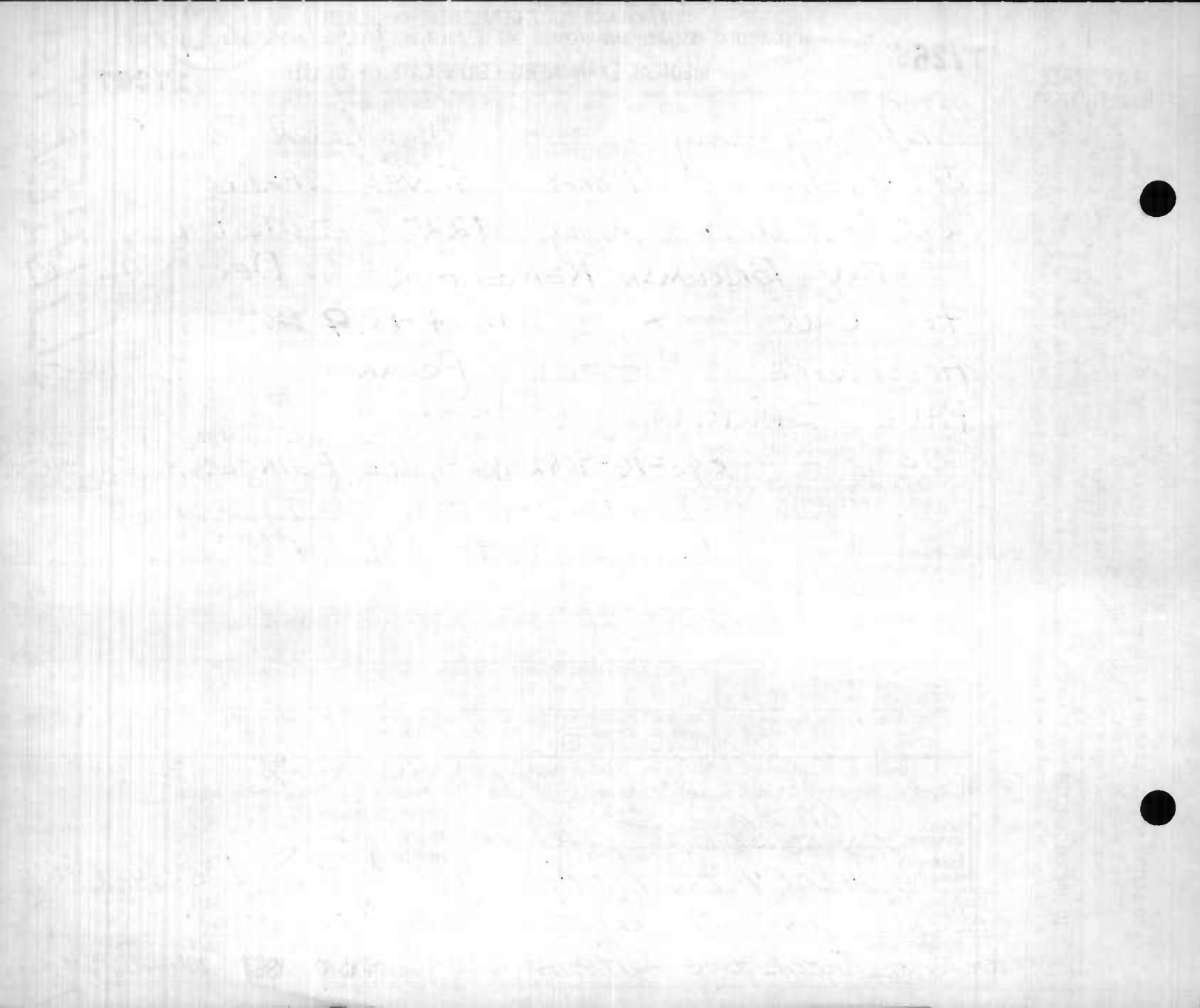
17267

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17267		17267	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>9 mos.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital, give street address) <i>1220 East West Highway</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FAY BRICKMAN KEMELHOR</b>		First	Middle
4. DATE OF DEATH <b>DEC. 4 1967</b>		Month	Year
S. SEX <i>Fe</i>	6. COLOR OR RACE <i>CAUC</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12-29-1892</b>		9. AGE (In years last birthday) <i>75 yrs.</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		11. BIRTHPLACE (State or foreign country) <i>POLAND</i>	
13. FATHER'S NAME <i>PAUL BRICKMAN</i>		14. MOTHER'S MAIDEN NAME <i>SARAH ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or No) <i>No</i>		16. SOCIAL SECURITY NO. <i>095-16-9082</i>	
17. INFORMANT <b>2521 AVALON PL., HYATTSVILLE Md. ADELE FEINGERSH (DAUGHTER)</b>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Acute Coronary Insufficiency</i>		DUE TO (b) <i>Coronary Artery Heart Disease</i> (c)	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. <i>4201</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D. Totowa</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-7-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON NAT'L Cem.</i>
23d. LOCATION (City or Town) <i>Arlington</i>		(County) (State) <i>V.A.</i>	
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home 4217 9th St. N.W.</i>		ADDRESS	
25a. REC'D BY REGISTRAR DATE <i>DEC. 8 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**1**  
17268  
**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY		Montgomery County		MARYLAND		o. STATE		Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Takoma Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring		Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Washington Sanitarium and Hospt		1 day		d. STREET ADDRESS		15 University Blvd.		e. IS RESIDENCE ON A FARM?	
e. ADDRESS		65001 Ridge Rd.				e. ADDRESS				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First James Middle Henry Last Kendall		HENRY		4. DATE OF DEATH		Month Dec. 19		Year 1967	
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday) 98 yrs.		IF UNDER 1 YEAR	
M		White		NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8-6-1869		Months		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Mercantile business		mercantile		Chicago, Illinois		U.S.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
George H. Kendall		Lastley									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		Md St. Aid 6043379690		Mr. Ernest Kendall Mr. James C. Kendall		504 Dennis Ave, S.S. 11811 Columbia Pike					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) 4341 Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Congestive heart failure 6 hrs.									
(b) Due to											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 1967, to 12/19, 1967, that (I) (we) last saw the deceased alive on 12/19 1967, and that death occurred at 6:15 P.M. from causes and on the date stated above.											
22a. SIGNATURE A. J. Thibadeau		22b. DATE SIGNED 12/20/67									
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
NAME (Type)		22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)	
Burial		Dec. 21, 1967		Parklawn Cemetery						Rockville, Maryland	
24. FUNERAL DIRECTOR		8434 ADDRESS		Georgia Avenue		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John B. Thomas Warner E. Humphrey, Inc.		Silver Spring, Md.				DATE DEC 27 1967		Charles Judge			

PAGE



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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CERTIFICATE OF DEATH						17269			
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>4 days</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xxxxxx</i>		b. COUNTY <i>xxxxxx</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>			e. STREET ADDRESS <i>1429-E. Capitol St.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>LEE</i>	Middle <i>B.</i>	Last <i>Kistler</i>	4. DATE OF DEATH <i>12 14 1967</i>	Month	Doy	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/3/84?</i>	9. AGE (In years last birthday) <i>83 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plate Printer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>US Gov't (Ret)</i>			11. BIRTHPLACE (County & State, or foreign country) <i>III.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Lemon Kistler</i>						14. MOTHER'S MAIDEN NAME <i>Orcelia (Last Name Unknown)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>579-60-2207</i>			17. INFORMANT Mrs. B. K. Lloyd, Potomac, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRAIN TUMOR</i>						INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ARTERIOSCLEROTIC VASCULAR DISEASE</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>New</i>	(County) <i>6</i>	(State) <i>1967</i>
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>12-13 1967</i> , and that death occurred at <i>9:20 AM</i> , from causes and on the date stated above.						22b. DATE SIGNED <i>12-14-67</i>			
22a. SIGNATURE <i>Bernard A Fitzgerald</i>			M.D. ATTENDING PHYS. <i>4</i>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <i>BERNARD A Fitzgerald</i>			22d. ADDRESS <i>217 Union Blvd E. Silver Sp. Md.</i>			23d. LOCATION (City or Town) <i>Suitland, Pr. Geo, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/18/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Suitland, Pr. Geo, Md.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Lee Funeral Home, 300 4th, NE, Wash, DC</i>						25a. REC'D BY REGISTRAR <i>Charles Juge</i>		25b. REGISTRAR'S SIGNATURE	
						DATE <i>DEC 18 1967</i>			

8887

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

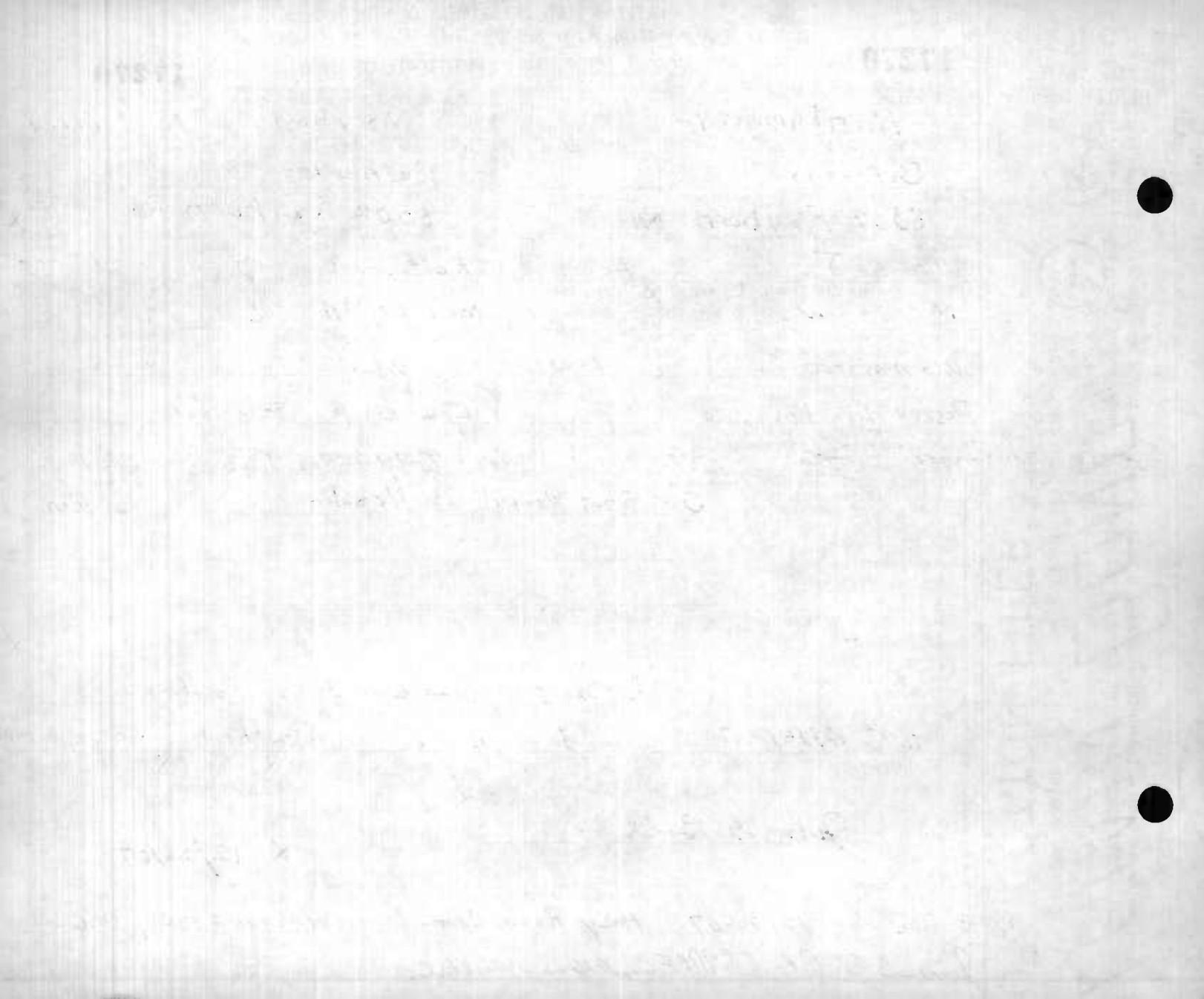
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**FOR STATE  
HEALTH DEPT.**

5  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm Bureau Page 5 may be retained for your files.

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17270		17270	
1. PLACE OF DEATH a. COUNTY <b>Montgomery -</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Montgomery -</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda.</b>		c. LENGTH OF STAY IN lb <b>15-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8502 Rayburn Rd.</b>		d. STREET ADDRESS <b>8502 Rayburn Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>J</b>		First <b>Leo.</b>	Middle <b>Kolb.</b>
4. DATE OF DEATH <b>December 26 1967</b>		Last	Month Day Year
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 13, 1911</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>56 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. MARSHALL</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH LEO KOLB, JR.</b>		14. MOTHER'S MAIDEN NAME <b>Louise A. STANZON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>II</b>	
17. INFORMANT <b>(Wife) MARY AGNES KOLB - SAME AS #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X</b> DUE TO <b>Gun Shot Wound of Head -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head with 38 cal. Revolver -</b>	
20c. TIME OF INJURY Month, Day, Year <b>Hour am. 7:00 p.m. 12/26/1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Bethesda, Montgomery, MD</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John S. Bell</b>		M.D.	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>12/26/67.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-30-67</b>	
		23c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Road Cem.</b>	
		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR <b>James E. Dr. Bell - DC Bell Funeral Home - Bethesda</b>		ADDRESS	
		25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

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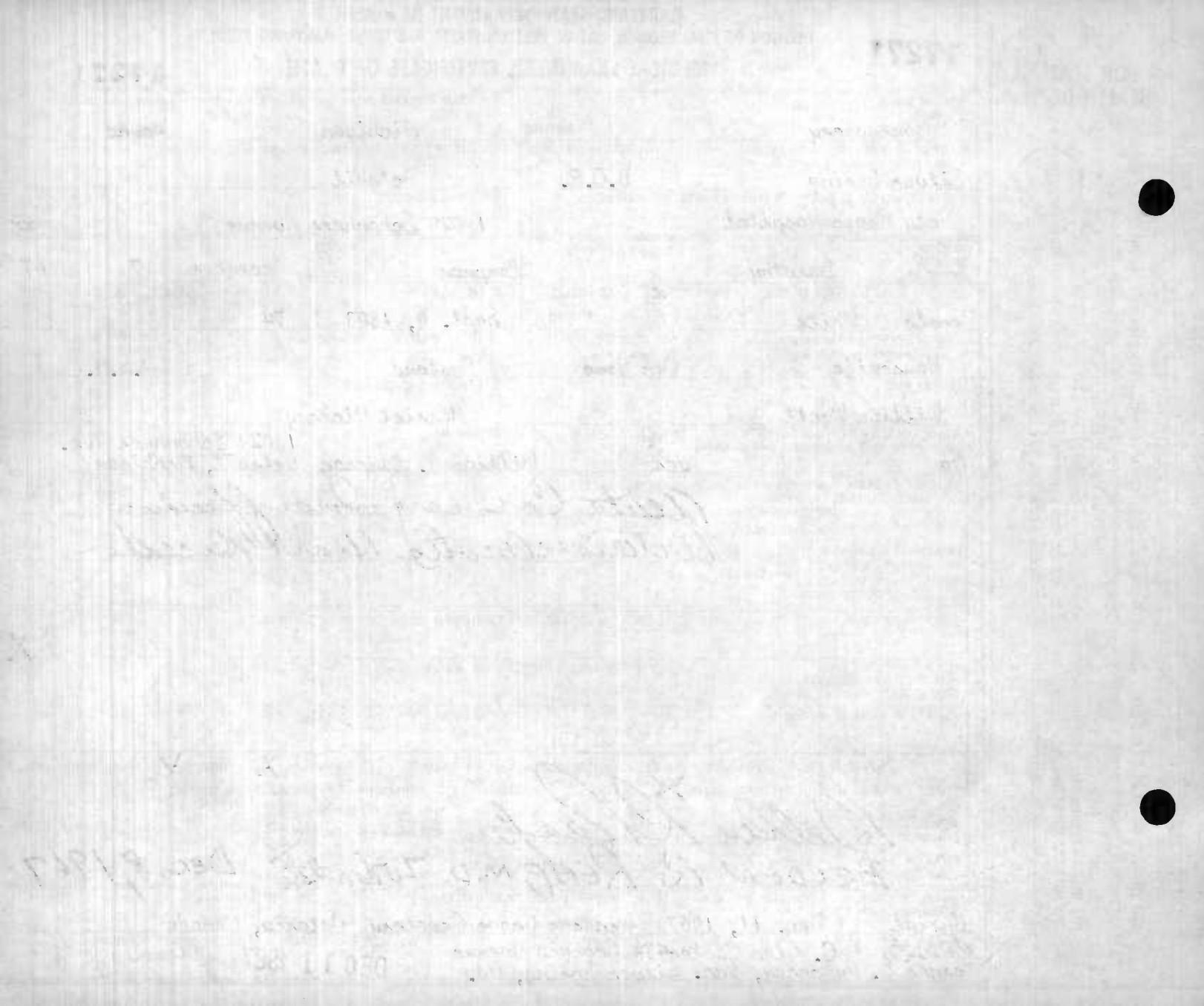
17271

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17271

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Michigan</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>D.O.H.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Dorothy</i>		First <i>Dorothy</i>	Middle <i>Lampman</i>
4. DATE OF DEATH <i>December 7 1967</i>	Month <i>December</i>	Day <i>7</i>	Year <i>1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>Sept. 9, 1893</i>
9. AGE (In years lost birthday) <i>74 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	12. BIRTHPLACE (State or foreign country) <i>England</i>
13. FATHER'S NAME <i>William Wyatt</i>	14. MOTHER'S MAIDEN NAME <i>Harriet Vickery</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>yes</i>	17. INFORMANT <i>William A. Lampman</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)	19. ADDRESS <i>18029 Schonheer Ave.</i>
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		
22. MEDICAL CERTIFICATION	23. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	24. FUNERAL DIRECTOR <i>G. Glen Carter</i>	25. DATE THEREOF <i>Dec. 11, 1967</i>
26. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	27. NAME OF CEMETERY OR CREMATORIAL <i>Windsor Grove Cemetery</i>	28. ADDRESS <i>8434 Georgia Avenue</i>	29. LOCATION (City or Town) <i>Ontario, Canada</i>
30. EXAMINER'S NAME (Type) <i>BElden R. REAP M.D.</i>	31. CHIEF MEDICAL EXAMINER <i>M.D.</i>	32. ASSISTANT MEDICAL EXAMINER <i>M.D.</i>	33. DEPUTY MEDICAL EXAMINER <i>M.D.</i>
34. DATE <i>DEC 11 1967</i>	35. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	36. DATE <i>DEC 11 1967</i>	37. ADDRESS <i>Warner E. Pumphrey, Inc., Silver Spring, Md.</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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<b>CERTIFICATE OF DEATH</b>						17272				
1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Maryland</b>		d. STREET ADDRESS <b>500 Highgate Terrace</b> <del>1500 Forest Glen Rd. Silver Spring, Md.</del>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital of Silver Spring</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				15-1		
3. NAME OF DECEASED (Type or print)	First <b>Mark</b>	Middle <b>Everett</b>	Last <b>Lavery</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>6</b>	Year <b>1967</b>	15-1		
5. SEX <b>male</b>	6. COLOR OR RACE <b>cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-28-66</b>	9. AGE (In years lost birthday) <b>16 months</b>	IF UNDER 1 YEAR Months <b>16</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>minor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>not employed</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John M. Lavery</b>				14. MOTHER'S MAIDEN NAME <b>Iris Mayberry</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mother - 500 Highgate Ter. Silver Spring, Md. IRIS LAVERY</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b>								INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>745X</b>				(b) <b>SCOLIOSIS + KYPHOSIS + DEFORMITY OF THORAX</b>				<b>16 mos</b>		
				(c) <b>BIRTH DEFECTS OF SPINE + ABS</b>				<b>16 mos</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC URINARY TRACT INFECTION DUE TO CONGENITAL G-U DEFECTS POSTOPERATIVE HYDROCEPHALUS + MYELOMeningocele</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1251 M.</b>		(County) <b>Prince Georges Co. Md.</b>	(State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7/31, 1966</b> , to <b>12/6, 1967</b> , that (I) (we) last saw the deceased alive on <b>October 8, 1967</b> , and that death occurred at <b>1251 M.</b> from causes and on the date stated above.										
22a. SIGNATURE <i>George Cohen</i>										22b. DATE SIGNED <b>12/6/67</b>
22c. PHYSICIAN'S NAME (Type) <b>George Cohen</b>		22d. ADDRESS <b>9919 Georgia Ave., Silver Spring, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Dec. 7, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>				
24. FUNERAL DIRECTOR <b>Thomas Deak Thomas</b> 8434 ADDRESS <b>Warner E. Lumpkey, Inc.</b> Silver Spring, Md.		25a. REC'D BY REGISTRAR <b>DEC 11 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, send in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

17273

**CERTIFICATE OF DEATH**

17273

**1. PLACE OF DEATH**

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Kensington

c. LENGTH OF STAY IN lb

3 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Carroll Hall Sanitarium

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

HATTIE

M. ay

LAYTON

4. SEX

6. COLOR OR RACE

Female

White

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

4. DATE  
OF  
DEATH

Dec

22

1967

B. DATE OF BIRTH

May 7, 1876

9. AGE (in years  
last birthday)

91 yrs.

10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

11. BIRTHPLACE (County & State, or foreign country)

Months

Days

Hours

Min.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Clarence Gram Head

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

579-62-8516-0 Margaret M. Graham

Address

417 Van Buren Street, N.W.

INTERVAL BETWEEN  
ONSET AND DEATH

5 days

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c))

PART I. DEATH WAS CAUSED BY;  
IMMEDIATE CAUSE (a)

442X

DUE TO

Conditions, if any, which  
give rise to immediate cause  
(e), stating the underlying  
cause last.

(b)

DUE TO

(c)

Acute Myocardial Failure

Cardiovascular Renal Disease

19. WAS AUTOPSY  
PERFORMED?

YES  NO

2. MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING  CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....

saw the deceased alive on..... and that death occurred at..... from the causes and on the date stated above.

22a. SIGNATURE

Myron H. Neiges,

22c. PHYSICIAN'S  
NAME (Type)

Lynwood Heights, MD, FACP

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED

23a. BURIAL OR CREMATION, DATE THEREOF

REMOVAL  
(Specify)

Burial

Dec. 27, 1967

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

SERVICE

Glen Carter

Warner

5. Pumphrey, Inc.

Silver Spring, Md.

ADDRESS

8434 Georgia Avenue

Washington, D.C.

Silver Spring, Md.

23d. LOCATION (City, town or county)

Leesburg, Va.

Wash. D.C.

24. FUNERAL DIRECTOR'S SIGNATURE

Oscar L. Warner

Charles J. Pumphrey

Inc.

Silver Spring, Md.

25a. REC'D BY REGISTRAR

Charles Judge

Dec 28 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

Dec 28 1967

ANITA A. DITTAH

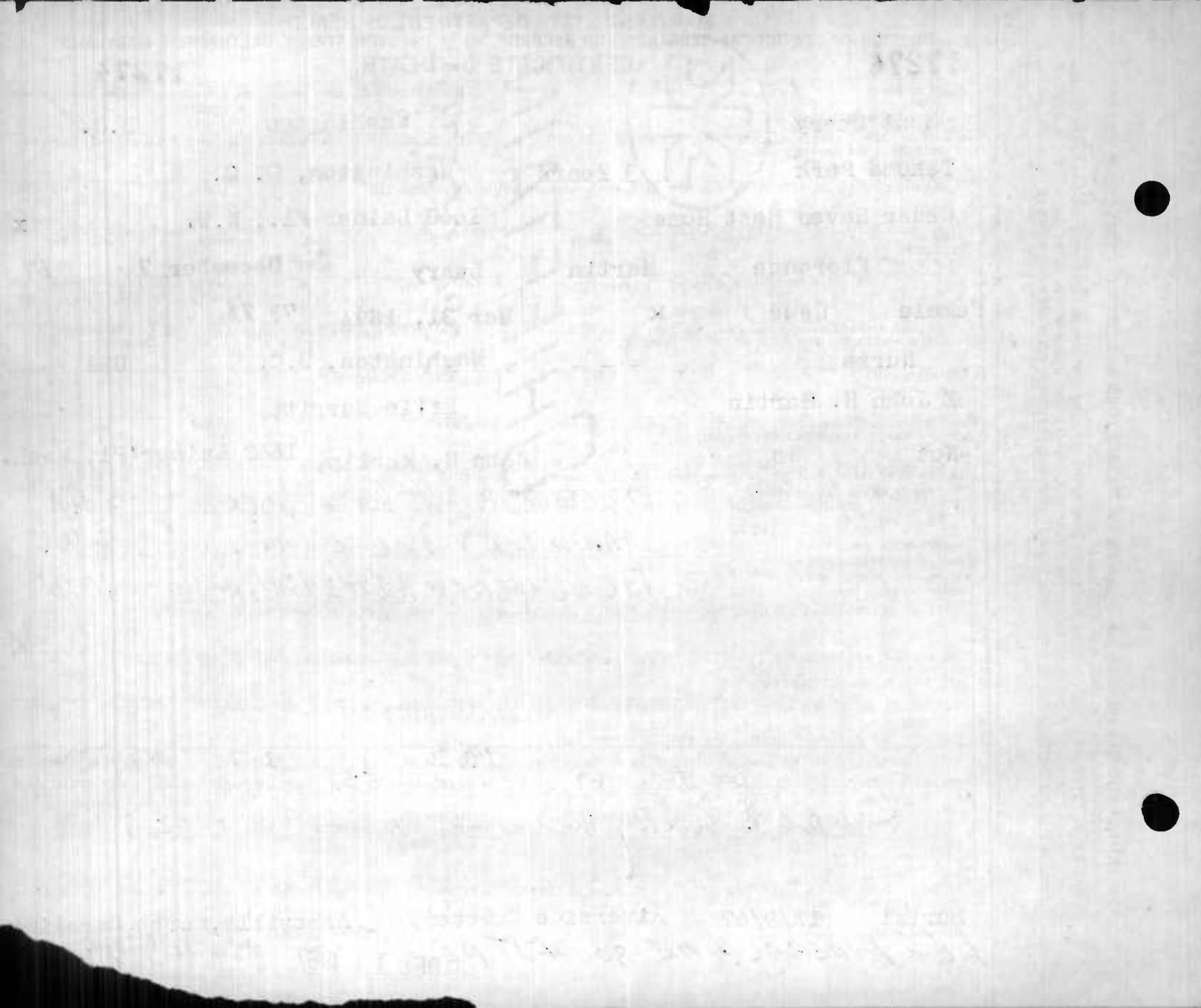


SEARCHED  
INDEXED  
SERIALIZED  
FILED  
APR 26 1968  
FBI - LOS ANGELES

*2*  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
17274														
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
Montgomery MARYLAND			a. STATE Washington b. COUNTY D.C.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47-3											
c. LENGTH OF STAY IN 1b Takoma Park 3 Years														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cedar Haven Rest Home			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Florence Martin			First Middle Last			4. DATE OF DEATH December 7 1967			Month Day Year					
5. SEX Female Cauc			6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH Mar 31, 1894			9. AGE (In years last birthday) 73 71 Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME E John H. Martin			14. MOTHER'S MAIDEN NAME Effie Burritt											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No			16. SOCIAL SECURITY NO.			17. INFORMANT			Address					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350X			DUE TO (b)			PNEUMONIA - Rt lower lobe			INTERVAL BETWEEN ONSET AND DEATH 3 days					
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			DUE TO (c)			PARKINSON'S DISEASE - Advanced			6 yrs					
GENERALIZED ALZHEIMER'S DISEASE									10 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1962, 19, to 12-7, 1967, that (II) (we) last saw the deceased alive on Dec 6, 1967, and that death occurred at 550 AM, from the causes and on the date stated above.														
22a. SIGNATURE Richard B. PERCY MD			22b. DATE SIGNED 12-7-67											
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/9/67			23c. NAME OF CEMETERY OR CREMATORIUM Riverside Cemetery			23d. LOCATION (City, town or county) Asheville, North Carolina (State)					
24. FUNERAL DIRECTOR Lee Funeral Home 300 45th N.E.			25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge											
ADDRESS			DATE 11 1967											



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			d. STREET ADDRESS <u>1204 Oakview Drive</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Robert</u>		First <u>R</u>	Middle <u>C</u>	Last <u>Charles</u>	Leary	4. DATE OF DEATH <u>Dec 7 1967</u>		Month <u>Dec</u>	Doy <u>7</u>	Year <u>1967</u>			
S. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/04</u>		9. AGE (In years lost birthday) <u>63 yrs.</u>		IF UNDER 1 YEAR <u>Months</u>	IF UNDER 24 HRS. <u>Days</u>	IF UNDER 24 HRS. <u>Hours</u>	IF UNDER 24 HRS. <u>Min.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass't. Administrator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Montana</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John C. Leary</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Kelly</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII</u>			16. SOCIAL SECURITY NO. <u>577-60-0117</u>			17. INFORMANT <u>Mrs. Margaret Leary</u>			1204 Oakview Drive Silver Spring, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>443X</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Hypertensive cardiovascular disease</u> DUE TO <u>lost</u> (c) <u>10 years</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>Md.</u>								
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1963</u> to <u>Dec 7 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 7 1967</u> , and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above.													
22a. SIGNATURE <u>Blaine H. E. T.</u>													
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. E. T.</u>		22d. ADDRESS <u>1641 Colenwood Rd Silver Spring Md.</u>			22e. DATE SIGNED <u>12/8/67</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) <u>Silver Spring, Md.</u> (County) <u>Montgomery</u> (State) <u>Md.</u>							
24. FUNERAL DIRECTOR <u>John Thomas Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>			25a. REC'D. BY REGISTRAR <u>DEC 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

spk # guttmacher  
mug # each number except

two

~~• rule 8<sup>th</sup> not as rule~~  
C-1941 ~~11-25~~  
6 (numbered levels) 11-59 ~~11-25~~ ~~11-31~~ 11-31

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

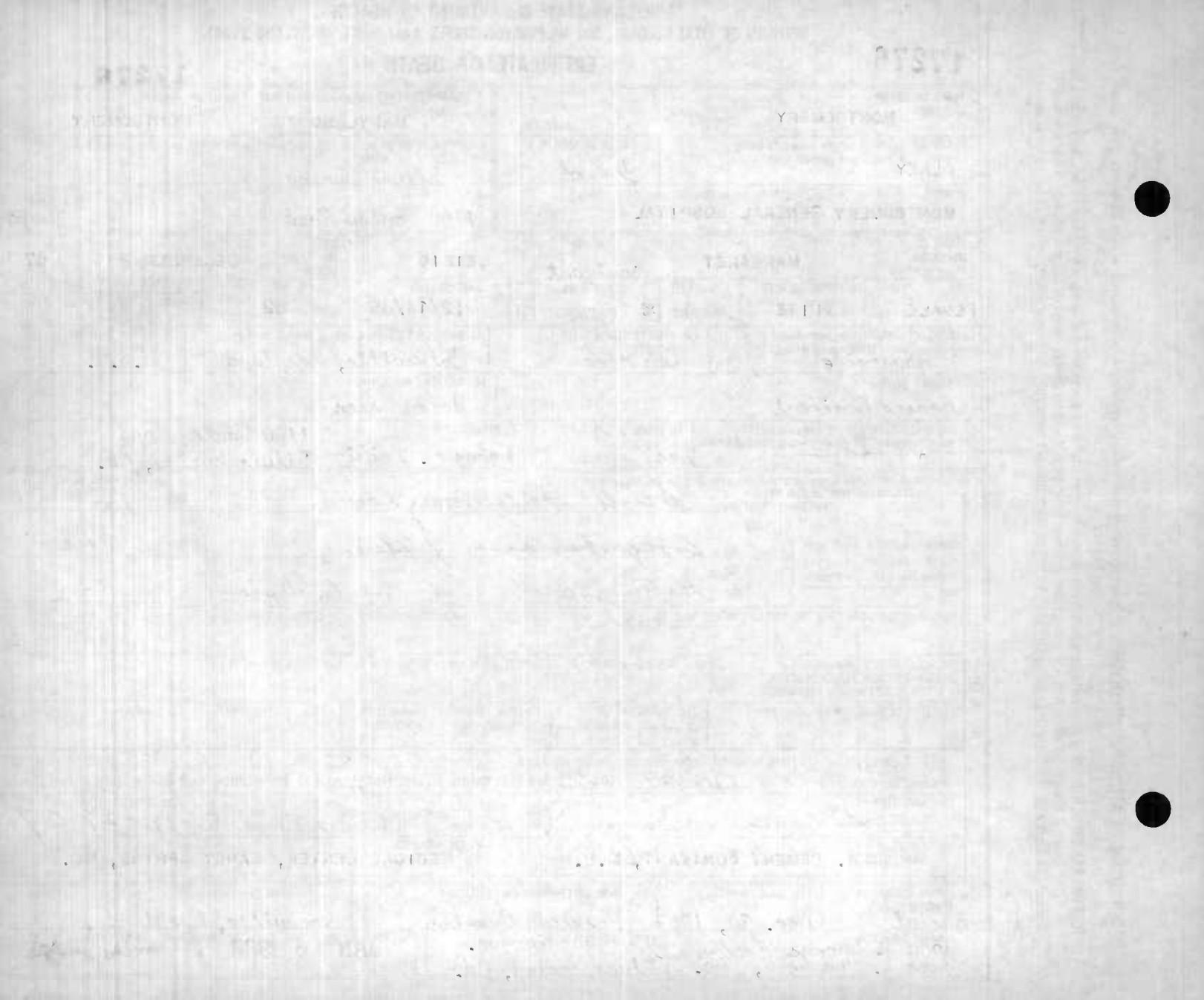
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VR A15  
25M 1/6

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL			d. STREET ADDRESS 1100 Tanley Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First MARGARET	Middle Bonifant	Last LEIBIG	4. DATE OF DEATH Month DECEMBER Day 28 Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12/14/85	9. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Colesville, Maryland	
13. FATHER'S NAME George Bonifant		14. MOTHER'S MAIDEN NAME Helen Green		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. yes		17. INFORMANT Thomas M. Leibig Address 1100 Tanley Road Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u> 48 hrs DUE TO (c) <u>arteriosclerotic cardiovascular disease</u> 15 min					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1952, to <u>Dec</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec 27</u> 1967, and that death occurred at <u>9:10 AM</u> from causes and on the date stated above.					
22a. SIGNATURE <u>A. Dement Bonifant, M.D.</u>		22b. DATE SIGNED <u>12-29-67</u>			
22c. PHYSICIAN'S NAME (Type) A. DEMENT BONIFANT, M.D.		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 30, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City or Town) Rockville, Maryland
24. FUNERAL DIRECTOR John E. Warner & Son, Inc.		ADDRESS 8434 Georgia Ave. Silver Spring, Md.	25a. RECD. BY REGISTRAR JAN 8 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>



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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH e. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE										
Montgomery MARYLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton			c. LENGTH OF STAY IN 1b										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home			d. STREET ADDRESS										
3. NAME OF DECEASED (Type or print)			First Susie	Middle Mary	Last Leigh	4. DATE OF DEATH	Month Dec	Day 6	Year 1967	e. IS RESIDENCE ON A FARM?			
5. SEX female			6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/1881	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Charlotte Co., Va.			12. CITIZEN OF WHAT COUNTRY? N.W.				
13. FATHER'S NAME Jamerson Fulton Mercer White			14. MOTHER'S MAIDEN NAME Mary Frances Henderson										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Irving Abramson			Address 2700 Newlands St Washington, DC				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)  4500													
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. (b) Generalized infected decubiti 3 mos. (c) Generalized atiosclerosis 4 yrs.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)													
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 6-20, 1967, to 12-6, 1967, that (I) (we) last saw the deceased alive on 11-7, 1967, and that death occurred at 12 PM, from the causes and on the date stated above.													
22e. SIGNATURE Herbert L. Tanenbaum, M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 12-6-67				
22c. PHYSICIAN'S NAME (Type) HERBERT L. TANENBAUM			22d. ADDRESS 4400 Coan Ave. NW Wash D.C.										
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/8/67			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION (City, town or county) Prince Georges Co. Md. (State)				
24 FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. Washington, D. C.			ADDRESS			25e. REC'D BY REGISTRAR DEC 7 1967			25b. REGISTRAR'S SIGNATURE Charles Judge				
VR AIS (4) 20M S-63													

Year 1930

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #7 film #G395 12/6/67 ph

CERTIFICATE OF DEATH

17278

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN lb MARYLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>				
f. STREET ADDRESS <b>11108 Post House Ct.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
h. DATE OF DEATH <b>MMY Dec. 1,</b>		Month	Doy Year			
i. NAME OF DECEASED (Type or print) <b>EMILIE L. LEPPERT</b>		Lost	19 67			
j. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>			
			NEVER MARRIED <input type="checkbox"/>			
			DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>April 9, 1889</b>		9. AGE (In years at last birthday) <b>78 yrs.</b>	10. IF UNDER 1 YEAR Months Doy Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>			
13. FATHER'S NAME <b>Anton Kees</b>		14. MOTHER'S MAIDEN NAME <b>Louise Steckenner</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-58-6515</b>				
17. INFORMANT <b>Mrs Charles E. Rogers</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Brain Syndrome</b> DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Arteriosclerosis (generalized)</b> DUE TO (c) <b>Decubitus</b>				
19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>10/25/67</b>	(County) <b>1967</b>	(State) <b>Post House Ct.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>10/25/67</b> to <b>12/1/67</b> , 1967 that (I) (we) last saw the deceased alive on <b>11/17/67</b> and that death occurred on <b>12/1/67</b> M, from causes and on the date stated above.						
22a. SIGNATURE <b>V. T. Joyce</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>4977 Battery Lane, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/4/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>	23d. LOCATION (City or Town) <b>Silver Spring, Md.</b>		(County) <b>MD</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE	
				DATE DEC 6 1967		
VR A15 (4) 25M 1/67						

775

всех постов

всех постов включая пограничные и военные

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>		c. LENGTH OF STAY IN lb <b>6 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b>		b. COUNTY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNIVERSITY NURSING HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>		f. STREET ADDRESS <b>6445 LUZON AVE N.W.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
h. DATE OF DEATH <b>Dec. 4, 1967</b>		i. MONTH <b>Month</b>		j. DAY <b>Doy</b>		k. YEAR <b>Year</b>					
l. NAME OF DECEASED (Type or print) <b>EVA</b>		First <b>AURELIA</b>		Middle <b>LESTER</b>		m. DATE OF DEATH <b>1-31-1887</b>		n. AGE (In years lost birthday) <b>80 yrs.</b>			
o. SEX <b>F</b>		p. COLOR OR RACE <b>Caucasian</b>		q. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		r. DATE OF BIRTH <b>1-31-1887</b>		s. IF UNDER 1 YEAR Months <b>0</b> Dows <b>0</b> Hours <b>0</b> Min. <b>0</b>			
t. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GOV'T CLERK</b>		u. KIND OF BUSINESS OR INDUSTRY <b>GOV'T</b>		v. BIRTHPLACE (County & State, or foreign country) <b>COLUMBIA S.C.</b>		w. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
x. FATHER'S NAME <b>William P. Lester</b>		y. MOTHER'S MAIDEN NAME <b>Minnie A. North</b>		z. ADDRESS							
aa. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		bb. SOCIAL SECURITY NO. <b>215-44-5379</b>		cc. INFORMANT <b>self</b>							
dd. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		ee. INTERVAL BETWEEN ONSET AND DEATH									
ff. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b>		<b>Cerebral thrombosis</b> <b>1 hour</b>									
gg. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>last.</b>		hh. (b) <b>Cerebrovascular insufficiency</b> <b>18 mos</b>									
ii. (c) <b>Arteriosclerosis, generalized</b> <b>years.</b>											
jj. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		kk. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
ll. MEDICAL CERTIFICATION 200. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Suitland, Md.</b> (State)					
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>July 1960</b> , to <b>Dec 4, 1967</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>12/2 1969</b> , and that death occurred at <b>8:15P.M.</b> from causes and on the date stated above.											
22a. SIGNATURE <b>James R. Coleman MD</b>		22b. DATE SIGNED <b>12/4/67</b>									
22c. PHYSICIAN'S NAME (Type) <b>JAMES R. COLEMAN</b>		22d. ADDRESS <b>9741 COLUMBIA BLVD SILVER SPRING, MD.</b>									
23a. BURIAL, CREMATION, burial		23b. DATE THEREOF <b>12/7/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland, Md.</b>		(County) <b>MD.</b> (State)			
24. FUNERAL DIRECTOR <b>J. H. Harris &amp; Son</b>		ADDRESS <b>2901 14th NW DC</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

ESTATE



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17280		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17280																	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>																								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					c. LENGTH OF STAY IN 1b <i>15 + years</i>					b. COUNTY <i>Montgomery</i>																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																								
3. NAME OF DECEASED (Type or print) <i>RUTH</i>					First	Middle	Last	4. DATE OF DEATH <i>DEC. 10 1967</i>																					
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 27, 1922</i>					9. AGE (In years lost birthday) <i>44 yrs.</i>																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>					11. BIRTHPLACE (County & State, or foreign country) <i>NEW YORK</i>																			
13. FATHER'S NAME <i>MAX CULLICOVER</i>					14. MOTHER'S MAIDEN NAME <i>-</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>- - -</i>					17. INFORMANT <i>HUSBAND SYDNEY LEVISON</i>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					Address <i>SAME</i>					INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i>					DUE TO <i>Cardio-Pulmonary insufficiency</i>					24 Hours																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>{ b) Carcinomatosis</i>					DUE TO <i>c) Infiltrating Duct Cell Carcinoma of Breast</i>					9 months 16 Months																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>None</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>					20c. TIME OF INJURY Month, Day, Year Hour: o.m. p.m.      19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1963</i> to <i>Dec. 10, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec. 10, 1967</i> , and that death occurred at <i>12:30 P.M.</i> from causes and on the date stated above.					22a. SIGNATURE <i>Gene U. Cohen, M.D.</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <i>Dec. 10, 1967</i>														
22c. PHYSICIAN'S NAME (Type) <i>GENE U. COHEN, M.D.</i>					22d. ADDRESS <i>1106 SPRING ST. SILVER SPRING, MD.</i>					23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE THEREOF <i>Dec. 11, 1967</i>					23c. NAME OF CEMETERY OR CREMATORIAL <i>B'Nai Israel Cemetery</i>					23d. LOCATION (City or Town) (County) (State) <i>Oxon Hill, Maryland.</i>				
24. FUNERAL DIRECTOR <i>Donald M. Stein Heb- new Memorial Funeral Home</i>					ADDRESS <i>232 Carroll St., N.W.-Wash., D.C.</i>					25a. REC'D BY REGISTRAR <i>DEC 18 1967</i>					25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>														

110-20

110-20-110000

110-20

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17281

## CERTIFICATE OF DEATH

17281

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN lb <i>14 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens SANITORIUM.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park.</i>	
3. NAME OF DECEASED (Type or print) <i>Florence C. Lewis</i>		First <i>F</i>	Middle <i>C.</i>
4. DATE OF DEATH <i>12/1/1967</i>		Month <i>12</i>	Doy Year <i>1 1967</i>
S. SEX <i>W</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>8-28-1886</i>		9. AGE (In years lost birthday) <i>81 yrs.</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Penna.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Henry Bowman</i>	
14. MOTHER'S MAIDEN NAME <i>Ida Morgan</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>172-01-033-88</i>		17. INFORMANT <i>Mr. David P. Reigel, 8606 Garland Ave. T.P.M.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Stomach</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterosclerotic Vascular Disease</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <i>None</i>		20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	
20f. (City or town) <i>None</i>		(County) <i>None</i>	
(State) <i>None</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1967</i> , to <i>Dec 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 1 1967</i> , and that death occurred at <i>35 P.M.</i> from causes and on the date stated above.			
22. SIGNATURE <i>Bernard A. Fitzgerald</i>			
22b. DATE SIGNED <i>12-1-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>		22d. ADDRESS <i>217 UNIV. BLVD. E., SILVER SPRING, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 7 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>West Darby Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>West Darby New York</i>	
24. FUNERAL DIRECTOR <i>Arthur Nutter, 252 Carroll St. N.W. 10</i>		25a. RECD BY REGISTRAR DATE DEC 5 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

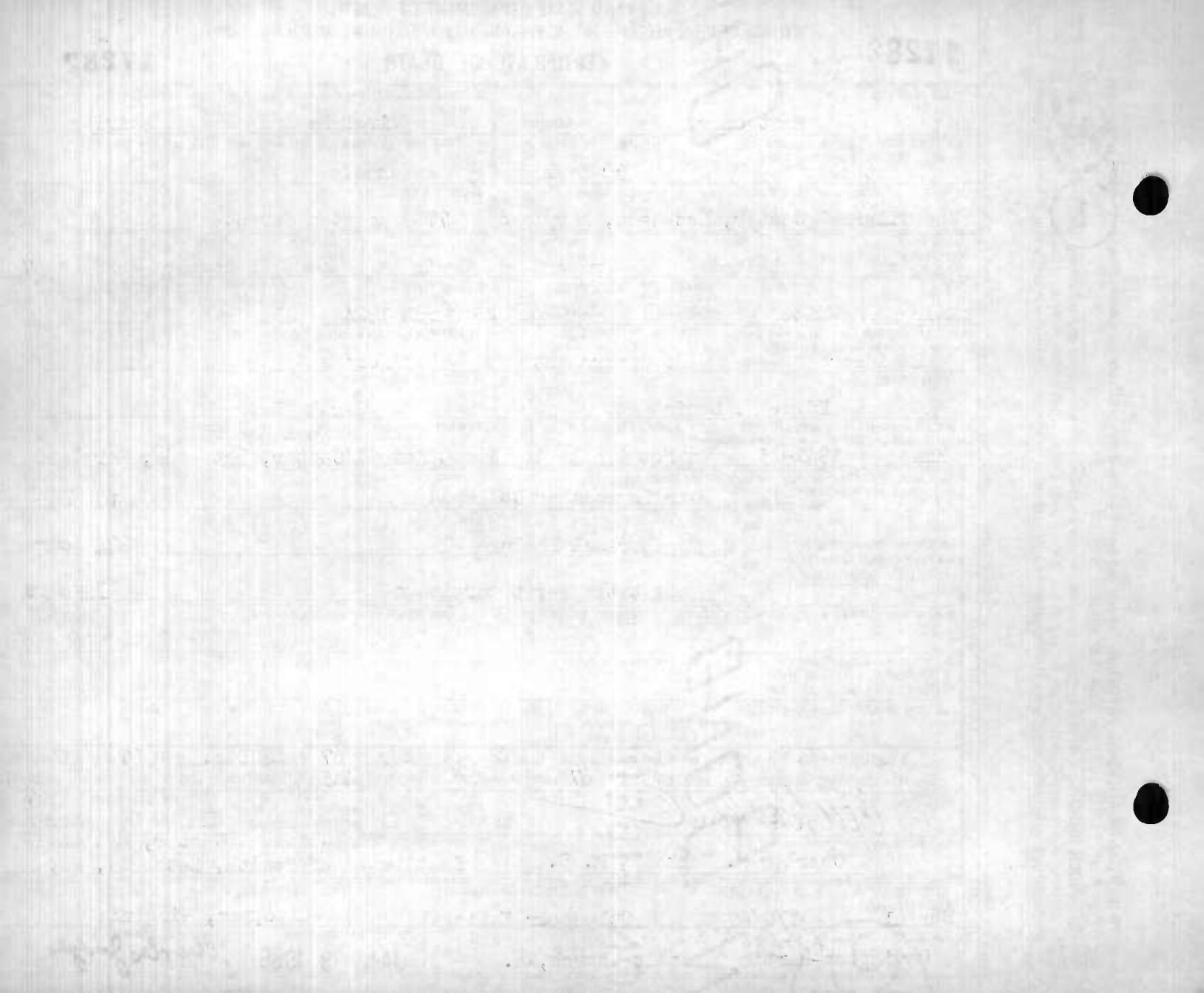
CERTIFICATE OF DEATH

17282

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, file this certificate, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
Montgomery MARYLAND		Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 30 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Leland	Middle Price
4. DATE OF DEATH		Month December	Doy 28 19 67
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 25 March 1924		9. AGE (In years lost birthday) 43 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY US Government	11. BIRTHPLACE (County & State, or foreign country) California
13. FATHER'S NAME Edgar H. Lewis		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1941-45	17. INFORMANT The Medical Records Address Not Available The Clinical Center, Bethesda, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992		INTERVAL BETWEEN ONSET AND DEATH in 10 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hepatorenal Failure		24 hours	
(c) Metastatic Teratocarcinoma		3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 28 November 19 67, to 28 Dec. 19 67, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 28 December 19 67, and that death occurred at 4:58 PM, from causes and on the date stated above.		22b. DATE SIGNED 1967 29 December	
22a. SIGNATURE <i>Charles Haskell</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Charles M. Haskell, M. D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/67	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) (County) (State) Culpepper, Virginia	
24. FUNERAL DIRECTOR <i>Robert Deral</i>		25a. ADDRESS	
Covington-Martin Falls Church, Va.		25b. REC'D BY REGISTRAR JAN 3 1968	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

3257



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file page 3 with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>MD.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>						c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium + Hospital 1707 Priscilla dr.</i>						d. STREET ADDRESS <i>151</i>					
3. NAME OF DECEASED (Type or print) <i>JESSE</i>						4. DATE OF DEATH First      Middle      Last      Month      Day      Year <i>EDGAR LITTLE      12      16      1967</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED WIDOWED      NEVER MARRIED      DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>12-16-88</i>		9. AGE (In years last birthday) yrs. <i>79</i>		10. IF UNDER 1 YEAR Months      Days      Hours      Min. <i>0      0      0      0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Claim Adjuster</i>						10b. KIND OF BUSINESS OR INDUSTRY <i></i>					
11. BIRTHPLACE (County & State, or foreign country) <i>ILL.</i>						12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>John Little</i>						14. MOTHER'S MAIDEN NAME <i>Jennie Walker</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i></i>					
17. INFORMANT <i>Pt. Chart.</i>						Address <i></i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage L. hemisphere</i> INTERVAL BETWEEN <i>331X</i> DUE TO <i>Arterioclerosis probably from</i> <i>hypertension</i> <i>ju</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)      (c) <i>ju</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.      19						20d. INJURY OCCURRED While at work      Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-4</i> , 19 <i>67</i> , to <i>12-16</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>8559 M.</i> from causes and on the date stated above.											
22a. SIGNATURE <i>Chas H. Voloshin</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>8-31-67</i>					
22c. PHYSICIAN'S NAME (Type) <i>Chas H. Voloshin</i>						22d. ADDRESS <i>831 University Blvd E 38</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						23b. DATE THEREOF <i>Dec. 19-1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Union Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore County, Md.</i>	
24. FUNERAL DIRECTOR <i>DeWitt Donaldson</i>						ADDRESS <i>Laurel, Md.</i>					
25a. REC'D BY REGISTRAR DATE <i>DEC 27 1967</i>						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE  
HEALTH DEPT.



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17284

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 2-16 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17284

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND MONTGOM.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 4 YEARS</b>		c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 151</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2122 ARCOLA AVENUE</b>		d. STREET ADDRESS <b>2122 ARCOLA AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>F.</b>	Last <b>LONG</b>
4. DATE OF DEATH	Month <b>DEC.</b>	Doy <b>5</b>	Year <b>1967</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1-17-1949</b>	9. AGE (In years last birthday) <b>18 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>STUDENT</b>	11. BIRTHPLACE (State or foreign country) <b>WASH., D.C.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>	11a. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	12. MOTHER'S MAIDEN NAME <b>EVELYN L. Riggs</b>	
13. FATHER'S NAME <b>JOHN B. LONG</b>	14. MOTHER'S MAIDEN NAME <b>EVELYN L. Riggs</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>212-54-2107</b>
17. INFORMANT <b>FATHER</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>9250</b> (b) DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	17. INFORMANT <b>2122 Arcola Avenue Silver Spring, Md.</b>
19. INTERVAL BETWEEN ONSET AND DEATH	<b>CARDIORESPIRATORY FAILURE DUE TO SUFFOCATION, ACCIDENTAL.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Decedent used plastic bag about head while inhaling medicine &amp; served in judgment.</b>	20c. TIME OF INJURY Month, Day, Year Hour <b>10</b> AM <b>12-5 1967</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>	20f. (City or Town) <b>Silver Spring</b>	20g. (County) <b>Montgomery</b>	20h. (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City or town or county) <b>Wheaton</b>		
ACTUAL SIGNATURE <i>Belden R. Reap</i>	22. DATE SIGNED <b>DEC. 6, 1967</b>		
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>	23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 8, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Rock Creek Cemetery 8434 Georgia Avenue</b>
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>	23d. LOCATION (City or Town) <b>Washington, D.C.</b>	25a. REC'D BY REGISTRAR <b>Charles J. Warner E. Pumphrey, Inc.</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Warner E. Pumphrey, Inc.</b>
VR A15ME (5) 6M 1/67	DATE <b>DEC 11 1967</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Dr. Koff*

*Cleared by medical examiner*

17285

CERTIFICATE OF DEATH

17285

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Grace</b>	Middle <b>C.</b>	4. DATE OF DEATH <b>December 31 1967</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years lost birthday) <b>75 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired clerk &amp; typist U.S. News &amp; World Report</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Baxter Clegg</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Atwater</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-28-6532</b>	
		17. INFORMANT <b>Robert B. Louthan</b>	
		Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic breast carcinoma</b>			
170X DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <b>in multiple viscera</b>			
DUE TO { (c) }			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Colleauith Rd.</b> (County) <b>S. S. Md.</b> (State)			
21. I certify that <b>11</b> (this hospital) attended the deceased from <b>Sept 17, 1958</b> , to <b>Dec 31, 1967</b> , that <b>11</b> (we) last saw the deceased alive on <b>Dec 31, 1967</b> , and that death occurred at <b>8:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Harry N. Carlton</i>			
22b. DATE SIGNED <b>Jan 1 1968</b>			
22c. PHYSICIAN'S NAME (Type) <b>HARRY N. CARLTON, MD</b>		22d. ADDRESS <b>8811 Colleauith Rd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1/3/68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>
23d. LOCATION (City or Town) <b>Prince Georges County, Md.</b>			
24. FUNERAL DIRECTOR <b>S.H. Hines Co. Wash. D.C.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>DATN 3 1968</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17286

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17286

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Germantown</i> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Germantown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rt #1 King Valley Rd.</i>		d. STREET ADDRESS <i>Rt #1 King Valley Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Herbert Julian Lowe</i>		First <i>J</i>	Middle <i>Julian</i>
4. DATE OF DEATH Month <i>Dec</i> Day <i>12</i> Year <i>1967</i>		Lost <i>L</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 31 1967</i>
9. AGE (In years lost birthday) yrs. <i>3 13</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Herbert Julian Lowe</i>	14. MOTHER'S M AIDEN NAME <i>Martha Baenhouse</i>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronch. Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>24 hr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Laytonsville</i> (County) <i>Montgomery</i> (State) <i>Md</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-13-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Laytonsville</i>
23d. LOCATION (City or Town) <i>Laytonsville, Mont. Md.</i> (County) <i>Montgomery</i> (State) <i>Md</i>			
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>		ADDRESS <i>Laytonsville, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 18 1967</i>
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

18571

WILSONS BIRDS OF THE WORLD

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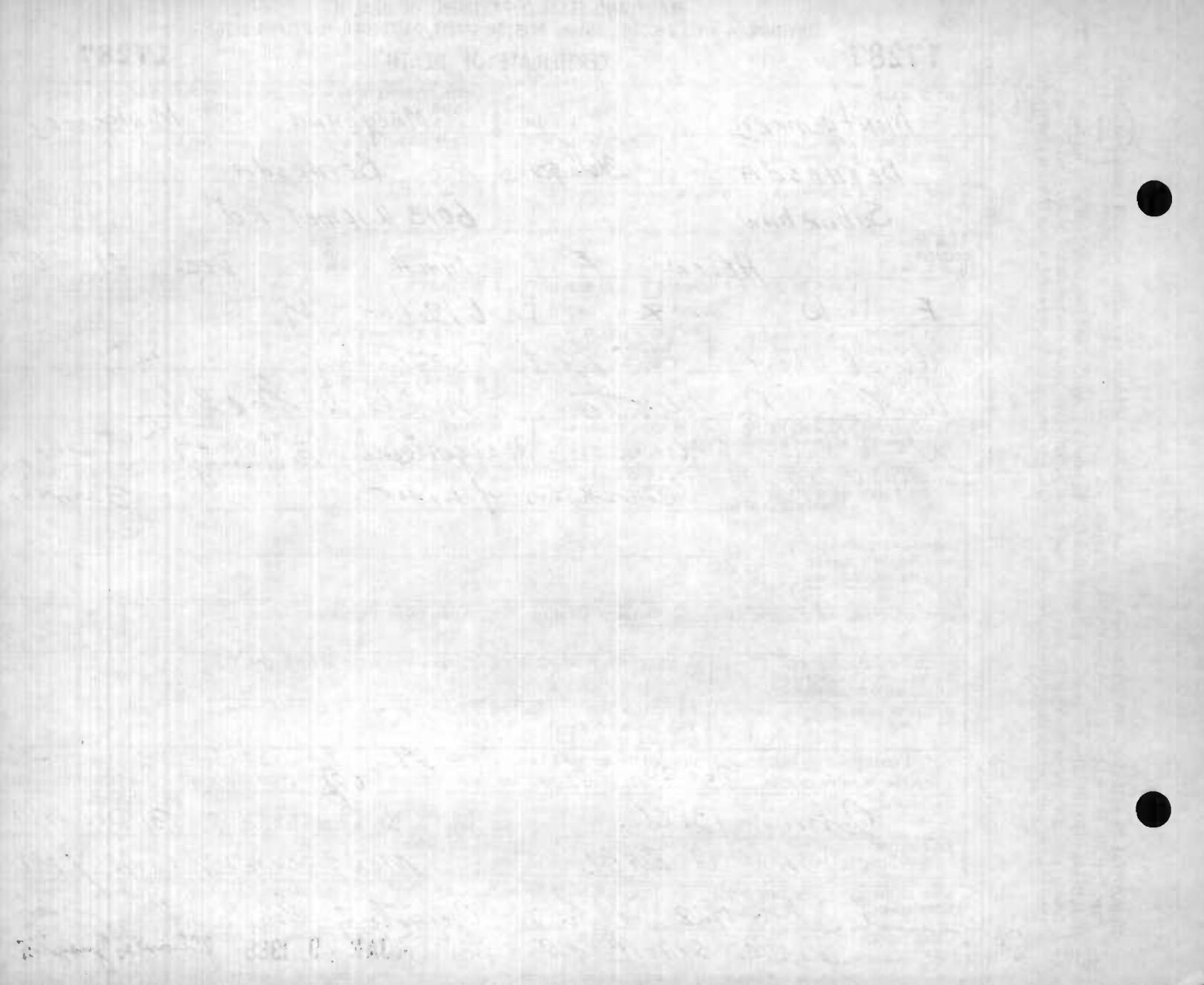
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17287		17287			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		b. COUNTY <u>Montgomery</u>			
c. LENGTH OF STAY IN 1b <u>No longer</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6013 Wilmet Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>HELEN</u>		First <u>F</u>	Middle <u>L</u>		
4. DATE OF DEATH <u>DEC 31 1967</u>		Last <u>LYNCH</u>	Month <u>DEC</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>6/21/00</u>		9. AGE (In years last birthday) <u>67 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Ross Watts</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Gochel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Margot Gray Birmingham Ala.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5810</u> DUE TO <u>Cirrhosis of Liver</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 29 1967</u> to <u>date</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 30 1967</u> , and that death occurred at <u>6:58</u> M, from causes and on the date stated above.		22b. DATE SIGNED <u>31 Dec 1967</u>			
22a. SIGNATURE <u>John G. Ball</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <u>31 Dec 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN G BALL</u>		22d. ADDRESS <u>MONTGOMERY COUNTY MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1-6-1968</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Hillside Cemetery</u>	
24. FUNERAL DIRECTOR <u>Mr. Chamberlain</u>		ADDRESS <u>517-115 SE DC</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg Md</u>	
25a. REC'D BY REGISTRAR <u>JAN 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>			



6/21  
Items 18-21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH  
1-15-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

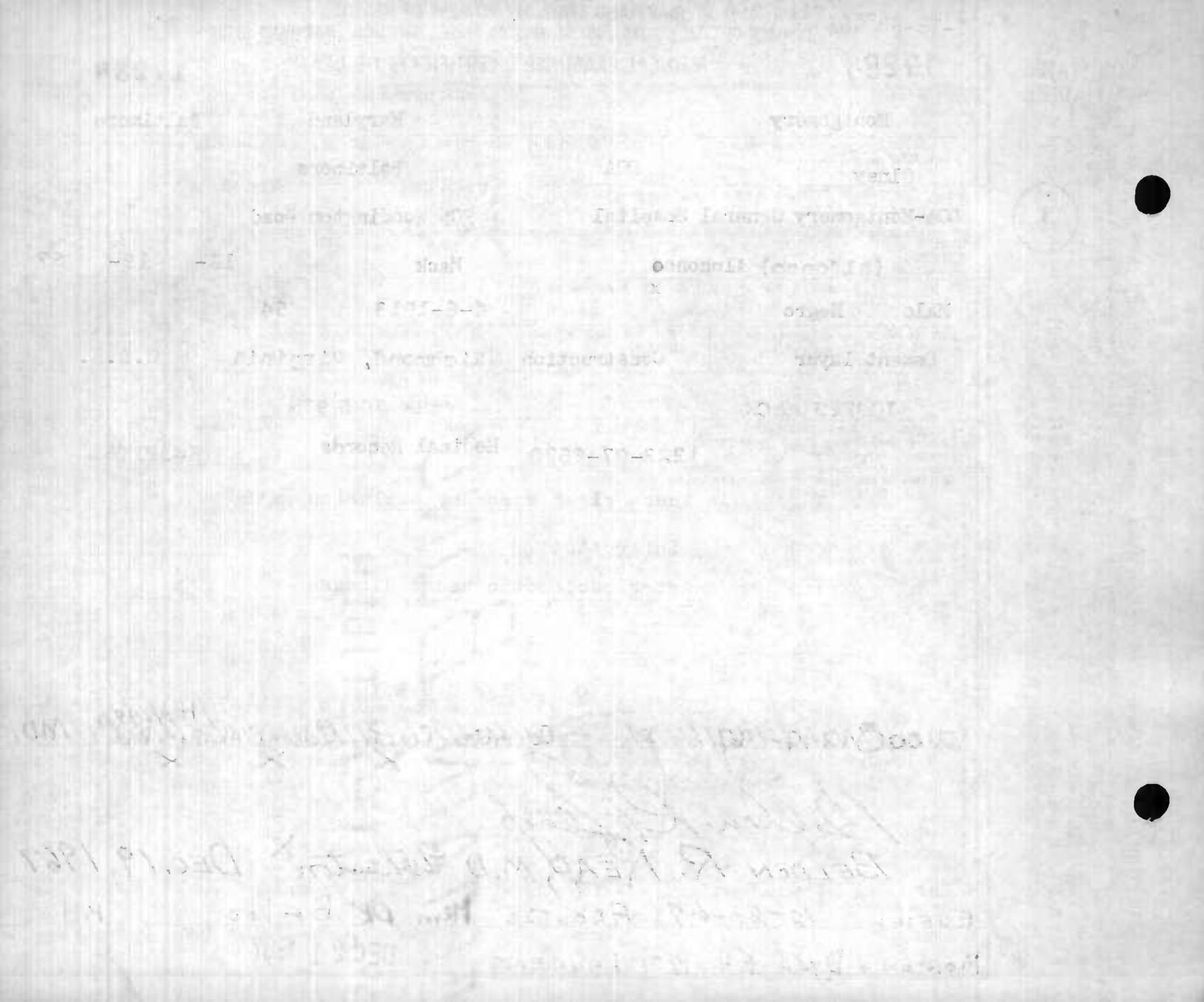
FOR STATE  
HEALTH DEPT.

11  
M  
1-15-68 ams  
P.M. 3 PM  
Page 1 of 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH								17288			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>				b. COUNTY <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA-Montgomery General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				30.4			
3. NAME OF DECEASED (Type or print) <b>(Alfonso) Alphonse</b>				First	Middle	Lost	4. DATE OF DEATH <b>Mack</b>	Month <b>12-</b>	Day <b>19-</b>	Year <b>1967</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-6-1913</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement layer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOSEPH MACK</b>				14. MOTHER'S MAIDEN NAME <b>VERA JOHNSON</b>				Address <b>HOSPITAL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <b>223-07-6620</b>			17. INFORMANT <b>Medical Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute right coronary occlusion with</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>infarction;</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>NO INJURY</b>							
20c. TIME OF INJURY Month, Day, Year Hour <b>12-19-1967</b>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Columbia / east / Columbia City / MD /</b>		20f. (City or town) <b>Hagerstown</b>		20g. (County) <b>Hagerstown</b>	(State) <b>MD</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22. DATE SIGNED <b>DEC. 19, 1967</b>	
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>12-23-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arbutus Mem. Park</b>		23d. LOCATION (City or Town) <b>Baltimore</b>		(County) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>MORTON + DYETT F.H. 1701 LAURENS</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 21 1967</b>		25b. REGISTRAR'S SIGNATURE <i>James J. Murphy</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

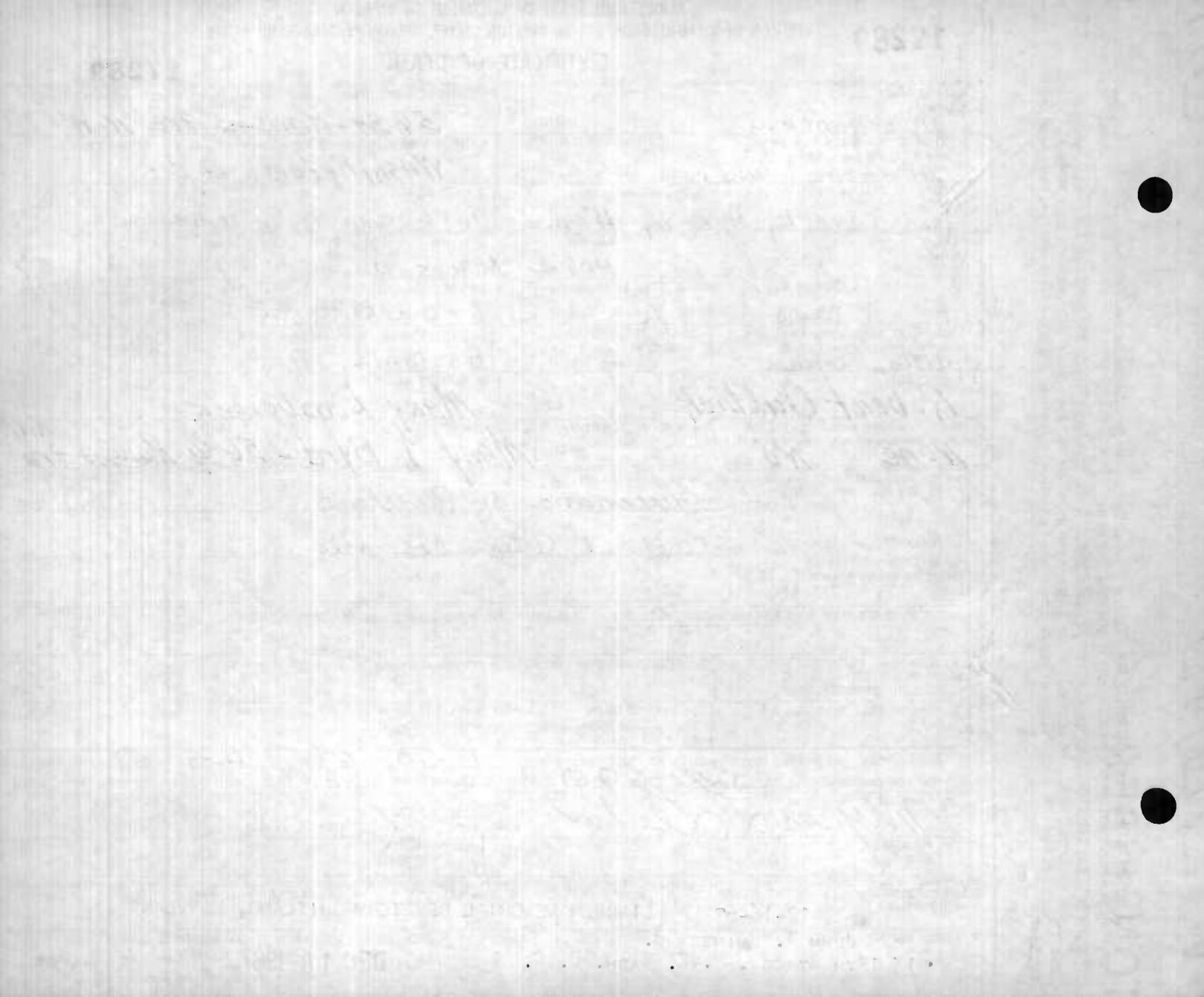
CERTIFICATE OF DEATH

17289

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the funeral.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>5634-Kansas Ave N.W. 1</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton, Md.</i>		c. LENGTH OF STAY IN 1b <i>6 wks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C. 473</i>		d. STREET ADDRESS <i>901 Arcola Ave - Wheaton</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>University Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>ESSIE</i>		First	Middle	Lost	4. DATE OF DEATH <i>12 9 1967</i>	Month	Day	Year
S. SEX <i>F</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>3-6-1882</i>	9. AGE (In years last birthday) <i>85 yrs.</i>	IF UNDER 1 YEAR Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Caterina Walker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Gaston, N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Robert Gullick</i>				14. MOTHER'S MAIDEN NAME <i>Mary Linzberger</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or rates of service) <i>None No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary J. Byrd - 5634 Kansas Ave</i>		Address <i>K.T.W.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>8 years</i>						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>157X</i>		Carcinoma of Pancreas						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>—</i>		DUE TO (b) <i>Cerebral Arterio sclerosis</i>						
		DUE TO (c) <i>—</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>11-10 1967</i> to <i>12-9 1967</i> that (I) (we) last saw the deceased alive on <i>12-8-67</i> and that death occurred at <i>64 M.</i> from causes and on the date stated above.								
22. SIGNATURE <i>Myron L. Leikin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS						
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>12-16-67</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>LINCOLN MEMORIAL CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>SUITLAND, MARYLAND</i>		
24. FUNERAL DIRECTOR JOHN T. RHINES CO. ADDRESS <i>#15 12TH STREET, N. E. WASH. D. C.</i>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
				DATE DEC 18 1967				



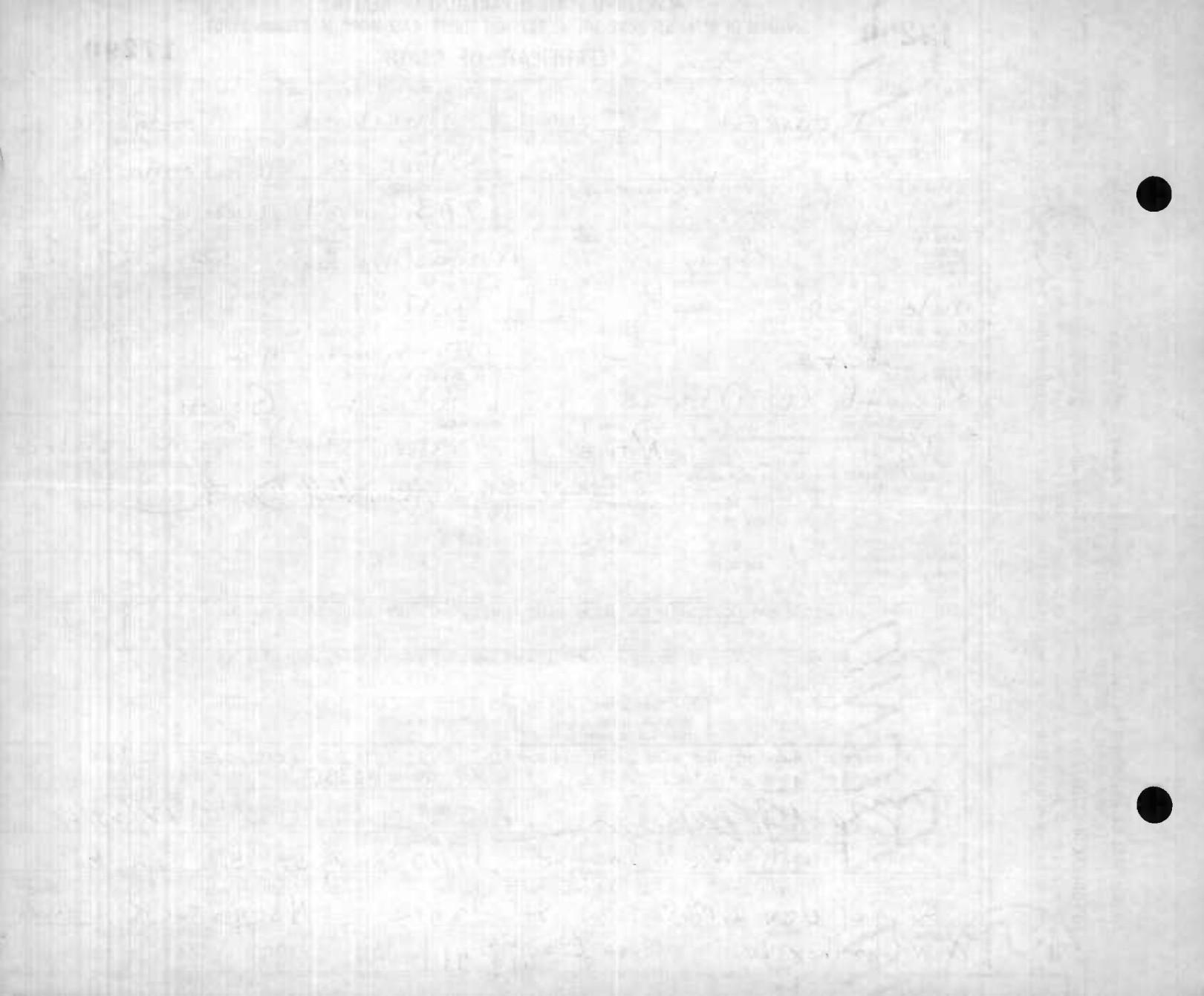
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove from papers. Pages 1, 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		17290				17290			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (Takoma Park)</u>		d. STREET ADDRESS <u>7713 Carroll Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>"Baby"</u>		First      Middle      Lost <u>Magas(m)</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White Caucasian</u>		7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-67</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Kenneth A. Magas</u>		14. MOTHER'S MAIDEN NAME <u>Rita L. Goyon</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Father (chart) - same as above</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<u>In maturity - Neonatal Death</u>				INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Am 12/27, 1967</u> , to <u>Pm 12/27, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/27/67 - Pm 19</u> , and that death occurred at <u>6:30 P.M.</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>Frank W. Neuberger</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/28/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>FRANK W. Neuberger</u>		22d. ADDRESS <u>1110 Spring St., S. L. Sprg., Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan. 2, 1968</u>		23b. DATE THEREOF <u>Jan. 2, 1968</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>St. James</u>		23d. LOCATION (City or Town) (County) (State) <u>Newington, Conn.</u>			
24. FUNERAL DIRECTOR <u>W.W. Chambers Inc.</u>		ADDRESS <u>8655 G. Ave S. L. Sprg., Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17291

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN lb <b>1 week</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Arthur J. Martineau</b>		First <b>Arthur</b>	Middle <b>J.</b>
4. DATE OF DEATH Month <b>Dec. 21</b>		Last <b>1967</b>	Doy Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>
13. FATHER'S NAME <b>Honorina Martineau</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Montague, Mass.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. # 1 578-01-6548</b>	17. INFORMANT Address <b>Mrs Mary Louise Martineau, Item 2</b>
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Advanced Arteriosclerotic Cardio-Vascular Disease with Multiple Cerebral Thrombi</b> DUE TO <b>4221</b>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b). DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that (I) (this hospital) attended the deceased from <b>November</b> , 19 <b>66</b> , to <b>December 21, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 21, 1966</b> , and that death occurred at <b>8:05 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>M. McKendree Boyer, M.D.</b>		22b. DATE SIGNED <b>December 22, 1966</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>9701 Church Street Damascus, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 23, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10571

Soil

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17292

CERTIFICATE OF DEATH

17292

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN 1b <b>University Nursing Home</b> <b>901 Arcola Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Eva</b>		First	Middle	Last	4. DATE OF DEATH <b>Mason</b>	Month	31	Day	Year	IF UNDER 1 YEAR	IF UNDER 24 HRS.	IF UNDER 1 MONTH	IF UNDER 24 HRS.		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>12/17/1889</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	Months	Days	Hours	Min.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress Catcher &amp; Feeder</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Williamston, No. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>James Rogers</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Scott</b>		Address											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-03-0668</b>		17. INFORMANT											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acetyl Cava + Dibutylbenzene</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4221</b> (b) <b>General Aging Process + Disability</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Suitland, Maryland</b>		(County) <b>Maryland</b>		(State) <b>MD</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>9/27</b> , 1967, to <b>12/31</b> , 1967, that (I) (we) last saw the deceased alive on <b>Dec. 27 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.															
22a. SIGNATURE <b>Russell C Bufalino</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <b>Jan 31 67</b>							
22c. PHYSICIAN'S NAME (Type) <b>Russell C Bufalino</b>		22d. ADDRESS <b>1429 University Blvd. W.</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-6-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>LINCOLN MEM. CEM.</b>		23d. LOCATION (City or Town) <b>SUITLAND, MARYLAND</b>		(County) <b>Maryland</b>		(State) <b>MD</b>					
24. FUNERAL DIRECTOR <b>Robert G. McGuire</b>		ADDRESS <b>1820 - 9th St. N.W.</b>		REG'D BY REGISTRAR <b>JAN 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17293

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**CLEARED WITH MEDICAL EXAMINER**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>1207 Benton St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		151	
3. NAME OF DECEASED (Type or print)	First <b>Earl</b>	Middle	Last Month May Year December 31 1967
4. DATE OF DEATH	Month	Day	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb 3, 1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Store Owner</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>Washington, D.C.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Notions</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isador May</b>		14. MOTHER'S MAIDEN NAME <b>Minnie David</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-24-0866</b>	
17. INFORMANT <b>Leah May, same as 2 above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Acute Coronary Occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>at once</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>ASHD &amp; CI</b> 10 yrs (c) DUE TO <b>Hypochondrosteolemia</b> 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , to <b>1967</b> , that (I) (we) last saw the deceased alive on <b>12/25 1967</b> , and that death occurred on <b>12/25 1967</b> AM, from causes and on the date stated above.		22b. DATE SIGNED <b>12/31/67</b>	
22a. SIGNATURE <b>Cyril A. Schneiman</b>		22d. ADDRESS <b>916-19th St NW Wash DC</b>	22b. DATE SIGNED <b>12/31/67</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-2-1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>National Memorial Park</b>
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		ADDRESS <b>4217-2nd St. N.W.</b>	25a. REC'D BY REGISTRAR DATE <b>3 1968</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>		d. STREET ADDRESS <b>3200 16th STREET N.W.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL HALL SANITARIUM</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>DAISY</b>		First <b>S.</b>	Middle <b>MAYFIELD</b>	Last	4. DATE OF DEATH <b>DECEMBER 30 1967</b>	Month <b>DECEMBER</b>	Day <b>30</b>	Year <b>1967</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 15, 1881</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			11. BIRTHPLACE (County & State, or foreign country) <b>MISSISSIPPI</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>D.D. STEPHENSON</b>					14. MOTHER'S MAIDEN NAME <b>ANNIE SHINN</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO				16. SOCIAL SECURITY NO. <b>577-07-2066</b>		17. INFORMANT <b>NURSINGHOME RECORDS</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>586x</b> (b) <b>cholecystectomy</b> DUE TO (c)										INTERVAL BETWEEN DEATH AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>arterio sclerosis</b>										INTERVAL BETWEEN DEATH AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fall</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>FT. LINCOLN CEMETERY</b>		20f. (City or town) <b>FT. LINCOLN</b> (County) <b>BLADENSBURG</b> (State) <b>P.G. CO., MD.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>12/29/1967</b> to <b>12/30/1967</b> , that (I) (we) last saw the deceased alive on <b>12/29/1967</b> , and that death occurred at <b>7:25 AM</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>E. Mayfield</b>					22b. DATE SIGNED <b>12-30-67</b>						
22c. PHYSICIAN'S NAME (Type) <b>R.E. Quayle</b>					22d. ADDRESS <b>1822 Biltmore St. N.W.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>12/30/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City or Town) <b>FT. LINCOLN</b> (County) <b>BLADENSBURG</b> (State) <b>P.G. CO., MD.</b>					
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS INC.</b>					ADDRESS <b>5130 WISC. AVE N.W.</b>						
25a. REC'D BY REGISTRAR <b>JAN 5 1968</b>					25b. REGISTRAR'S SIGNATURE <b>Joseph Gawler</b>						

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**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

## CERTIFICATE OF DEATH

17295

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>	c. LENGTH OF STAY IN TB <b>5 yrs 10 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>All States Hotel</b>		b. COUNTY <b>47-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens SANITORIUM</b>		d. STREET ADDRESS <b>Washington, D.C.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MAX</b>	Middle <b>C.</b>	Last <b>McCAFFREY</b>	4. DATE OF DEATH <b>12-25-1967</b>	Month Day Year		
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 26 1870</b>	9. AGE (In years lost birthday) <b>97 yrs.</b>	IF UNDER 1 YEAR Months <b>Days</b>	IF UNDER 24 HRS. Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gov. employee</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Hugh McCaffrey</b>				14. MOTHER'S MIDDLE NAME <b>JAN Spring Kennedy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-60-2228</b>		17. INFORMANT <b>E. Murray Norman-17th. &amp; H. St. N.W.</b>		Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>480X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
(b) DUE TO <b>Influenza</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized arteriosclerosis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 24, 1967</b> , to <b>Dec 25, 1967</b> , that (I) (he) last saw the deceased alive on <b>Dec 24, 1967</b> , and that death occurred at <b>7:00 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Michael R. Dobridge</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec 25, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Michael R. Dobridge</b>		22d. ADDRESS <b>12600 Parkland Drive, Rockville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Congressional Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1531 Rock. Pike Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

#### **• • • • •** *Conclusions*

17296

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

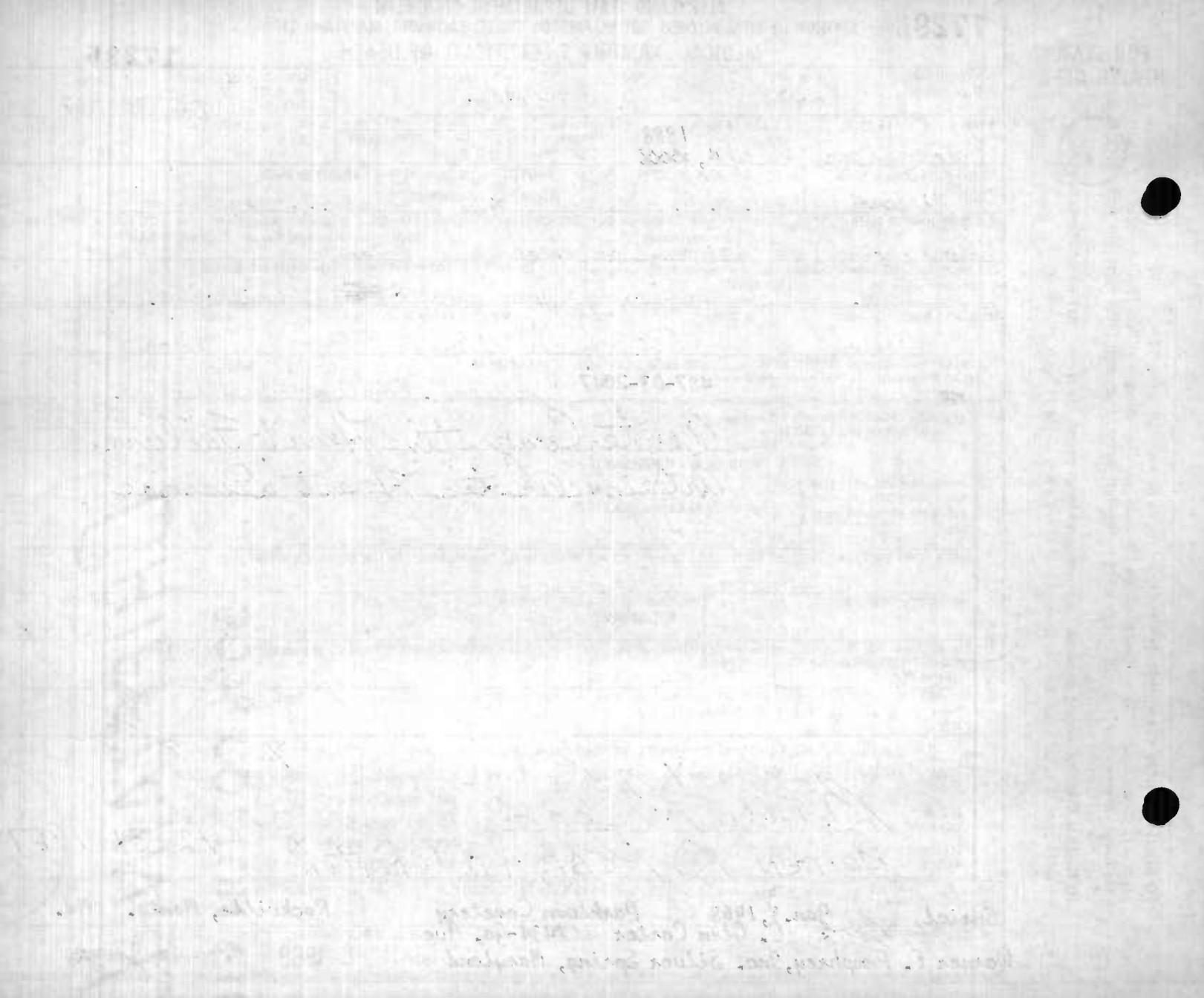
17296

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First <i>Donald</i>	Middle <i>H.</i>	Last <i>McAllum</i>	20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI. DEATH MATED <input type="checkbox"/> <i>Dec 30 1967</i> M	2b. HOUR M		
3. SEX <i>Male</i>	4. RACE <i>Cauc</i>	S. DATE OF BIRTH <i>May 2 1888</i>	6. AGE (In years last birthday) <i>70 YRS</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD Month Day Year <i>Jan 19 1968</i> M	2d. HOUR M
7d. BIRTHPLACE (State or foreign country) <i>Missouri</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>15 Hamilton Street</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Salesman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Paint</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13c. CITY OR TOWN <i>Montgomery Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>15 Hamilton St.</i>		
14. FATHER'S NAME First <i>William</i>		Middle <i>McCallum</i>	Last <i>Alice</i>	15. MOTHER'S MAIDEN NAME First <i>Risbop</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>487-03-2047</i>		17. INFORMANT <i>William R. McCallum 15 Hamilton Ave.</i>		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerotic Heart Disease</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>WHILE AT WORK</i> <input type="checkbox"/> <i>NOT WHILE AT WORK</i> <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>P.M.</i> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED <i>WHILE AT WORK</i> <input type="checkbox"/> <i>NOT WHILE AT WORK</i> <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Belden R. Reap</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>12-31-1967</i>		
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D., Rockville</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan. 3, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>		
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc. Silver Spring, Maryland</i>		ADDRESS <i>C. Glen Carter 8434 Ga. Ave</i>		REC'D BY REGISTRAR <i>JAN 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17297

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or the hospital or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
<i>Montgomery</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>200 ft</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>S JAY</i>		First	Middle
4. DATE OF DEATH <i>Dec. 10 1967</i>		Month	Year
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>January 15-1894</i>		9. AGE (In years last birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Dots <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington - DC</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Jay McCathram Sr.</i>	
14. MOTHER'S MAIDEN NAME <i>Eaton - Frances Josephine</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>577-54-1410</i>		17. INFORMANT Address <i>Cherry Chase - Mt. Pleasant - Washington 20006</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Coronary artery disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
(b) <i>Coronary artery - Sclerosis</i> DUE TO (c)		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Emphysema</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>67</i> , to <i>2-10, 1967</i> , that (I) (we) lost saw the deceased alive on <i>12-5-1967</i> , and that death occurred at <i>9:03 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>12-10-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>RUSSELL M. TILLEY</i>		22d. ADDRESS <i>4701 MASS. AVENUE N. W., WASHINGTON DC</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION <i>12/11/67</i>		23b. DATE THEREOF <i>CEDAR HILL</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 23d. LOCATION (City or Town) (County) (State) <i>SUITLAND, MD.</i>
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, 5130 WIS. AVE. N.W. WASH.		25a. REC'D BY REGISTRAR DATE <i>DEC 15 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



*2*  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

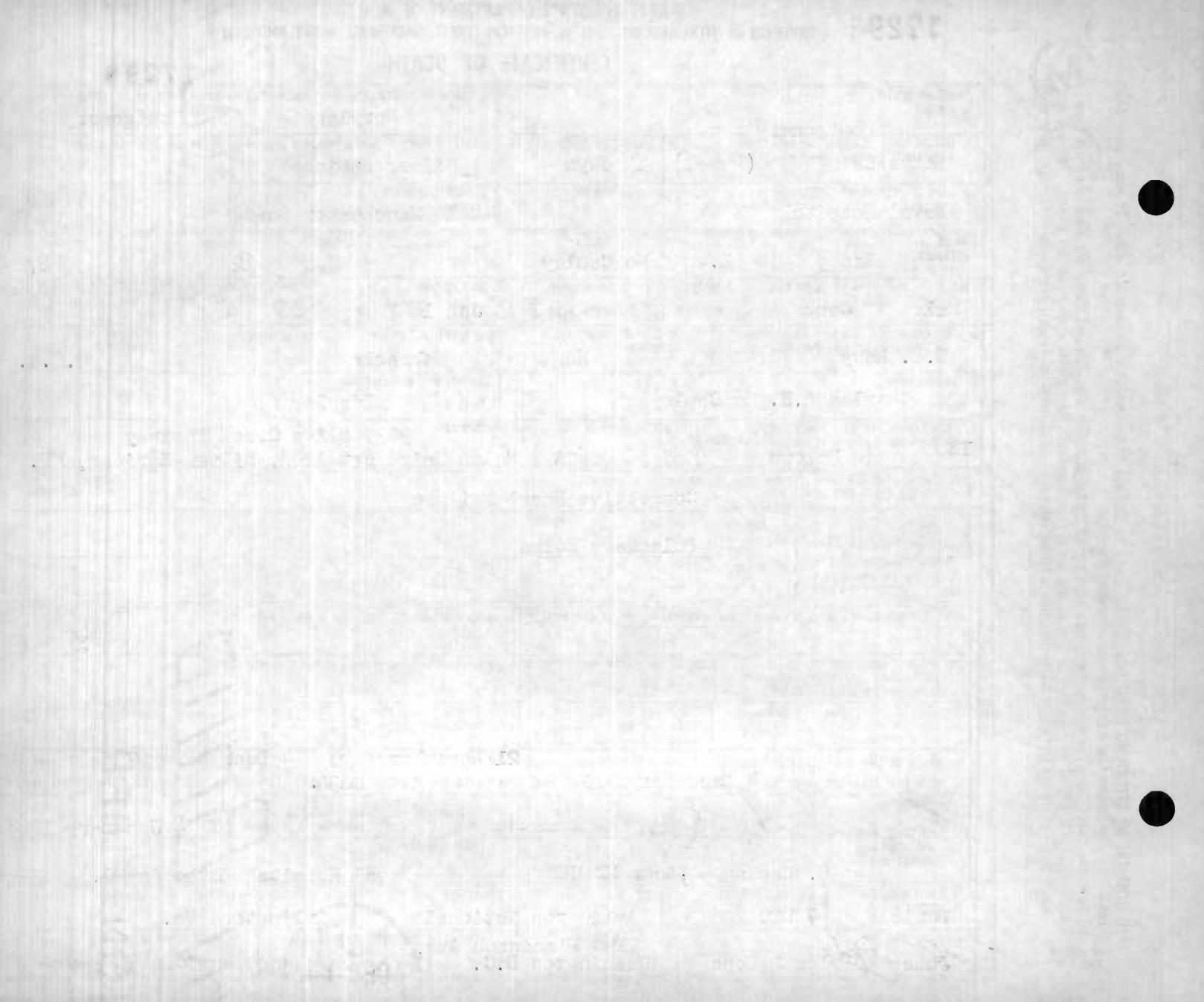
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**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17298 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17298

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 13 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver springs		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d. STREET ADDRESS 8610 Manchester Road		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Tracy First L. Middle Mc Cauley Last			4. DATE OF DEATH 12 Month 4 Day 19 Year 67		
S. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 4 Jan 1887	9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) Nebraska	
13. FATHER'S NAME Charles A.H. Mc Cauley			14. MOTHER'S MAIDEN NAME Ida Lay		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES Unknown		16. SOCIAL SECURITY NO. 565 16 8062A		17. INFORMANT 9039 Sligo Creek Parkway Helen Baird apt 1208, Silver Springs, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Edema</u>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>21 November, 1967</u> , to <u>4 December 1967</u> , that (I) (we) last saw the deceased alive on <u>4 December 1967</u> , and that death occurred at <u>0630 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <i>Eugene A. Kaplan</i>					
22c. PHYSICIAN'S NAME (Type) S. Kaplan, Lcdr MC USN		22b. DATE SIGNED 4 January 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7 DEC 1967	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.
24. FUNERAL DIRECTOR <i>Joseph Lawler &amp; Sons</i>		ADDRESS 5130 Wisconsin Ave, Washington D.C.		25a. REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

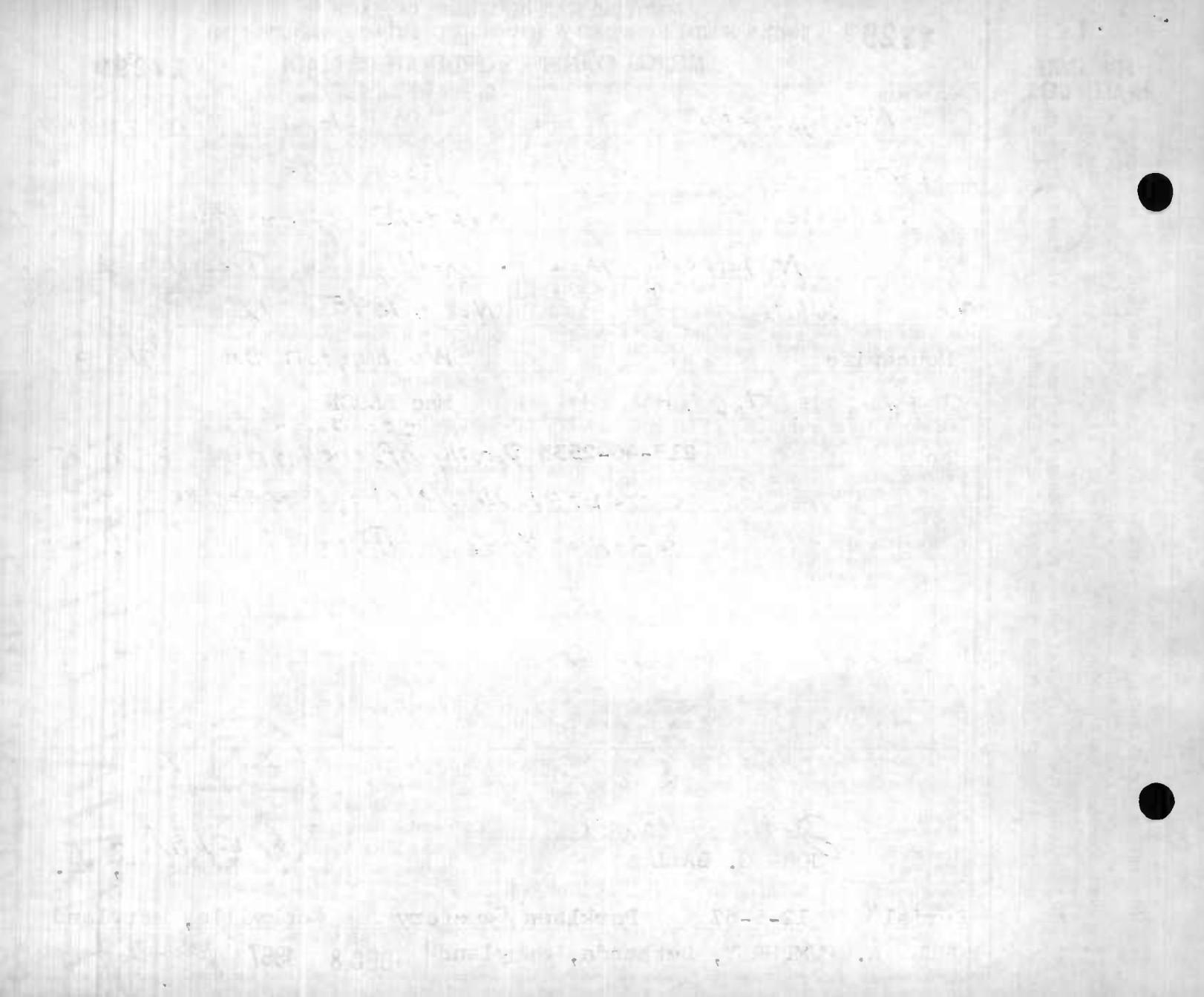
17299

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17299

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>3 hr 30 min</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mildred</i>	Middle <i>Mae F.</i>	Last <i>Nedley</i>
4. DATE OF DEATH <i>December 2</i>	Month <i>1967</i>	Day <i>1967</i>	Year
S. SEX <i>F</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 7, 1895</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>
13. FATHER'S NAME <i>J. Edward Fowler</i>		14. MOTHER'S MAIDEN NAME <i>Mae AARON</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-46-2533</i>	17. INFORMANT <i>Dorothy F. Purnell (Sister)</i> Address <i>3201 Bacon St Wash D.C.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage - Massive</i> DUE TO <i>4221</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 m -</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Cardio-Vascular Disease</i> (c)		Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>	M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
22. DATE SIGNED <i>12/3/67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-5-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>
23d. LOCATION (City or Town) <i>Rockville, Maryland</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS <i></i>	25a. REC'D BY REGISTRAR DATE <i>DEC 8 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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11:52 PM  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17300

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN lb <b>20 Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban.</b>		d. STREET ADDRESS <b>9902 Inglemere Dr.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Robert</b>	Middle <b>C</b>	Last <b>MELENENY</b>
4. DATE OF DEATH	Month <b>DEC</b>	Day <b>29</b>	Year <b>1967</b>
5. SEX <b>m</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 10-1915</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANICAL Eng</b>		9. AGE (In years (last birthday) yrs.) <b>52</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>EVANSTON ILL</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert C MELENENY</b>		14. MOTHER'S MAIDEN NAME <b>Stephanie CLARK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES.</b> If yes give war or dates of service <b>1941 - 1946</b>		16. SOCIAL SECURITY NO. <b>315-10-8415</b>	
17. INFORMANT <b>Jane A MELENENY</b> (wife)		Address <b>SAME.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>3561</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>b) Acute Respiratory Failure</b>			
DUE TO <b>c) Amyotrophic Lateral Sclerosis</b>		<b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9</b>
20f. (City or town) <b>Dec. 30, 1967</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 29, 1949</b> , to <b>DEC. 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>DEC 29, 1967</b> , and that death occurred at <b>11:52 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert G. Angle</b>		22b. DATE SIGNED <b>Dec. 30, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert G. Angle</b>		22d. ADDRESS <b>5009 Del Ray Ave. Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Jan 2 1968</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Pr. Geo Md</b>	
24. FUNERAL DIRECTOR <b>Robert A Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Charles J. George</b>	
ADDRESS <b>7557 Wisconsin Ave Bethesda, Md</b>		25b. REGISTRAR'S SIGNATURE <b>DATE JAN 5 1968</b>	

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be similar to the one I have in the  
bottom right corner. The version in  
the left hand

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

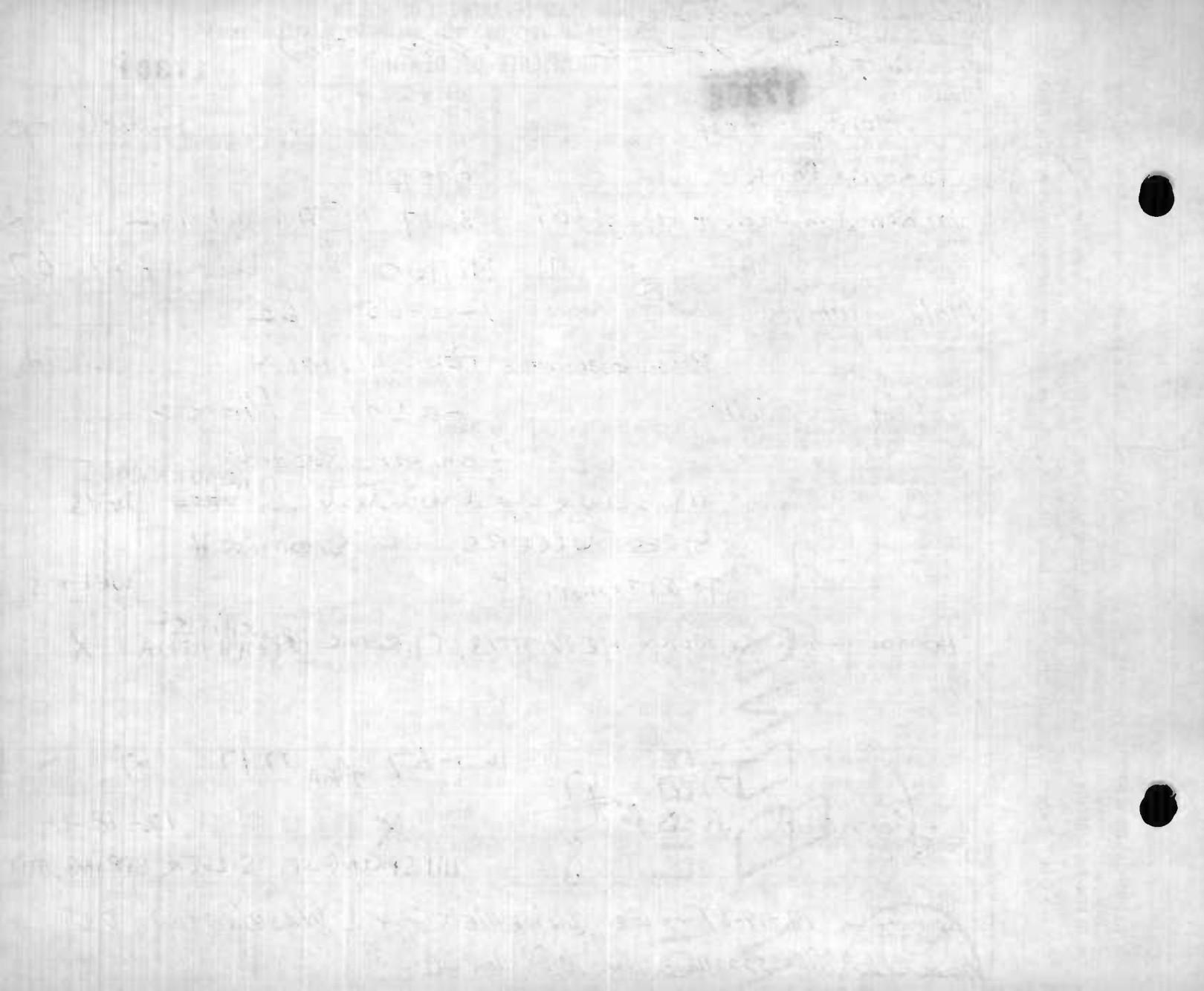
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released to Georgetown MARYLAND STATE DEPARTMENT OF HEALTH  
Medical School DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
for Scientific purposes

CERTIFICATE OF DEATH

17301

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. + Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>A. Russell Miller</i>		First <i>A.</i>	Middle <i>Russell</i>
4. DATE OF DEATH Month <i>December</i>		Day <i>17</i>	Year <i>1967</i>
s. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input type="checkbox"/> <i>Never married</i>	8. DATE OF BIRTH <i>1-2-05</i>
9. AGE (In years last birthday) <i>62 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Rixon Electronics</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Clayton Miller</i>	14. MOTHER'S MAIDEN NAME <i>Lavinia Pierce</i>	Address <i>Hospital Records</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>If yes give war or dates of service</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5410</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>STRESS ULCERS OF STOMACH</i> ? DUE TO (b) <i>PERITONITIS</i> WEEKS (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Homologous serum hepatitis, chronic bronchitis, emphysema</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11-7-67</i> , 19 <i>67</i> , to <i>12-7-67</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>12-7-67</i> , 19 <i>67</i> , and that death occurred at <i>7:00 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Leonard L. Deit</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12-18-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Leonard L. Deit</i>	22d. ADDRESS <i>111 Spring St. Silver Spring, MD</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE THEREOF <i>12-19-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>F.G.O. Univ. Med. Sch.</i>	23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON, D.C.</i>
24. FUNERAL DIRECTOR <i>James E. DeVol - 2223 Wisconsin Ave., N.W. - Wash DC</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 2 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



Items 18&21 Film 398 MARYLAND STATE DEPARTMENT OF HEALTH  
3-11-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
17302				17302								
1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			d. STREET ADDRESS <b>1412 HAMPSHIRE West Court</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANATORIUM &amp; Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <b>BRENDA</b>	Middle <b>GAY</b>	Lost <b></b>	4. DATE OF DEATH <b>12 8 1967</b>	Month <b>12</b>	Doy <b>8</b>	Year <b>1967</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-29-45</b>	9. AGE (In years lost birthday) <b>22 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James Miller</b>						14. MOTHER'S MAIDEN NAME <b>Loretta Layne</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>PEGGY ADER</b>		Address <b>SAME</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute, severe, bilateral,</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <b>Hemorrhagic, bronchopneumonia</b> DUE TO (c)												
INTERVAL BETWEEN ONSET AND DEATH												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Belden R. Rear</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>DEC. 8, 1967</b>				
EXAMINER'S NAME (Type) <b>BELDEN R. REAR, M.D., Wheaton</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (if different from above) (County) <b>Mountain View Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Maher, West Virginia</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 12, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mountain View Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Maher, West Virginia</b>						
24. FUNERAL DIRECTOR <b>J. S. Thomas</b>		ADDRESS <b>Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						
6M 1/67		DATE <b>DEC 13 1967</b>										

the *so-called* *soft* *soil*

10-112-19312 2021 August

Module 1: Introduction to Geostatistics and Spatial Data Analysis

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE  Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 63 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynchburg	b. COUNTY  83-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md.		d. STREET ADDRESS 1000 Wise Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Erna Last Millner		4. DATE OF DEATH Month December Day 27 1967 Year	
5. SEX Female White		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH 1921 27 September
8. AGE (In years lost birthday) 48 yrs.		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard G. Eagle		14. MOTHER'S MAIDEN NAME Pearl J. Phelps	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-22-9378	
17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2041 (b) Chronic Myelogenous Leukemia DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 1 day	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 25 October, 1967, to 27 Dec., 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 27 December 1967, and that death occurred at 8:48 M, from causes and on the date stated above.		22b. DATE SIGNED 1967	
22a. SIGNATURE Bruce Chabner		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 1967	22c. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.
22c. PHYSICIAN'S NAME (Type) Bruce Chabner, MD		23d. LOCATION (City or Town) (County) (State) APPOMATOX COUNTY, VIRGINIA	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 30, 1967	23c. NAME OF CEMETERY OR CREMATORIUM EAGLE FAMILY CEMETERY
24. FUNERAL DIRECTOR WHITTEN FUNERAL HOME, INC.		ADDRESS LYNCHBURG, VA.	25a. REC'D BY REGISTRAR DATE JAN 2 1968
			25b. REGISTRAR'S SIGNATURE Charles Judge

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*10* 1 **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

*17304*

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>7 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. &amp; Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
3. NAME OF DECEASED (Type or print) <i>Mary Elberta Mills</i>		d. STREET ADDRESS <i>15105 Peach Orchard Rd</i>	
3. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>9-8-02</i>		9. AGE (In years last birthday) <i>65 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. Mills</i>		14. MOTHER'S MAIDEN NAME <i>Rosie Williams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-46-5191</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>			
DUE TO (b) <i>Widespread metastatic carcinoma</i>			
DUE TO (c) <i>Heart - Pulmonary + osseous</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Burtonsville</i>
20f. (City or town) <i>Burtonsville</i>		(County) (State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1962</i> , to <i>12-20</i> , 1967, that (I) (we) last saw the deceased alive on <i>12-19</i> 1967, and that death occurred at <i>Burtonsville</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Joseph E. Smith Jr.</i>			
22c. PHYSICIAN'S NAME (Type) <i>Joseph E. Smith M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>Burtonsville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 23, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Burtonsville Cemetery</i>
24. FUNERAL DIRECTOR <i>John B. Humphries, Inc.</i>		23d. LOCATION (City or Town) <i>Burtonsville, Md.</i>	
25. ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25e. REC'D BY REGISTRAR <i>DEC 27 1967</i>	25f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

17305		17305												
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>					c. LENGTH OF STAY IN lb <b>20 days/13 hrs.</b>					b. COUNTY <b>Prince Georges</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>					d. STREET ADDRESS <b>1721 Merrimac Dr.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Alvin</b>	Middle <b>Ernest</b>	Last <b>Mitchell</b>	4. DATE OF DEATH		Month <b>DEC</b>	Day <b>6</b>	Year <b>1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-99</b>		9. AGE (In years last birthday) <b>68 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Carpentry</b>			11. BIRTHPLACE (Country & State, or foreign country) <b>Ashville, N.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Oscar Mitchell</b>			14. MOTHER'S MAIDEN NAME <b>Ellen Merrill</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>578-10-6732</b>			17. INFORMANT <b>Alvin R. Mitchell</b> Address <b>Hospital Records 1721 Merrimac Dr. Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>									INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5271</b>			DUE TO (b) <b>CHRONIC COR PULMONAL</b>											
			DUE TO (c) <b>PULMONARY EMPHYSEMA</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>UREMIA</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>														
21. I certify that (1) (this hospital) attended the deceased from <b>11/16</b> , 1967, to <b>12/6</b> , 1967, that (1) (we) last saw the deceased alive on <b>12/16</b> 1967, and that death occurred at <b>8:37 PM</b> , from causes and on the date stated above.														
22a. SIGNATURE <b>Ira N. Dublin</b>												22b. DATE SIGNED <b>12/6/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Ira N. Dublin</b>			22d. ADDRESS <b>800 PERSHING, DR. S.S. M.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Dec. 11, 1967</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Mausoleum</b>			23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, County, Md.</b>					
24. FUNERAL DIRECTOR <b>Glen Carter</b>			24b. ADDRESS <b>8434 Georgia Ave.</b>			25a. REC'D. BY REGISTRAR <b>Charles Judge</b>			25b. REC'D. BY CLERK'S SIGNATURE <b>Charles Judge</b>					

2032



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17306

17306

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <b>EDWARD</b>	Middle <b>GERARD</b>	Last <b>MONTGOMERY</b>	2a. DATE OF DEATH Month <b>Dec.</b> Day <b>20,</b> Year <b>1967</b>	2b. HOUR 10 <sup>12</sup> <i>P.M.</i>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>May 10, 1878</b>		6. AGE (In years last birthday) <b>89</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Nebraska</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Valley N. H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Economist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Chevy Chase</b>	13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>24 W. Kirke Street</b>		
14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First <b>Elizabeth Mooney</b>		Middle		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Nancy Montgomery</b>	Address <b>Same as Item 13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> <b>Carcinomatous</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma, the Prostate</b> (c) <b>Coronary, the Prostate</b>						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic Heart Disease</b>						
5 2	4 1	3 2	2 1	1 2	0 1	1 2
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1961</b> , 19 <sup>61</sup> , to <b>Dec. 20</b> , 19 <sup>67</sup> , that (I) (we) last saw the deceased alive on <b>Dec. 20</b> , 19 <sup>67</sup> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Wm Kelley MD</i>	DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>Dec 21 1967</b>	
22d. PHYSICIAN'S NAME (Type) <b>William H. Kelley</b>	22e. ADDRESS <b>8218 Wisconsin Ave, Bethesda</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-22-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) <b>Washington, D. C.</b>	(County)	(State)	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>	ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>	25a. RECD BY REGISTRAR <b>DEC 26 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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30371

17307

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

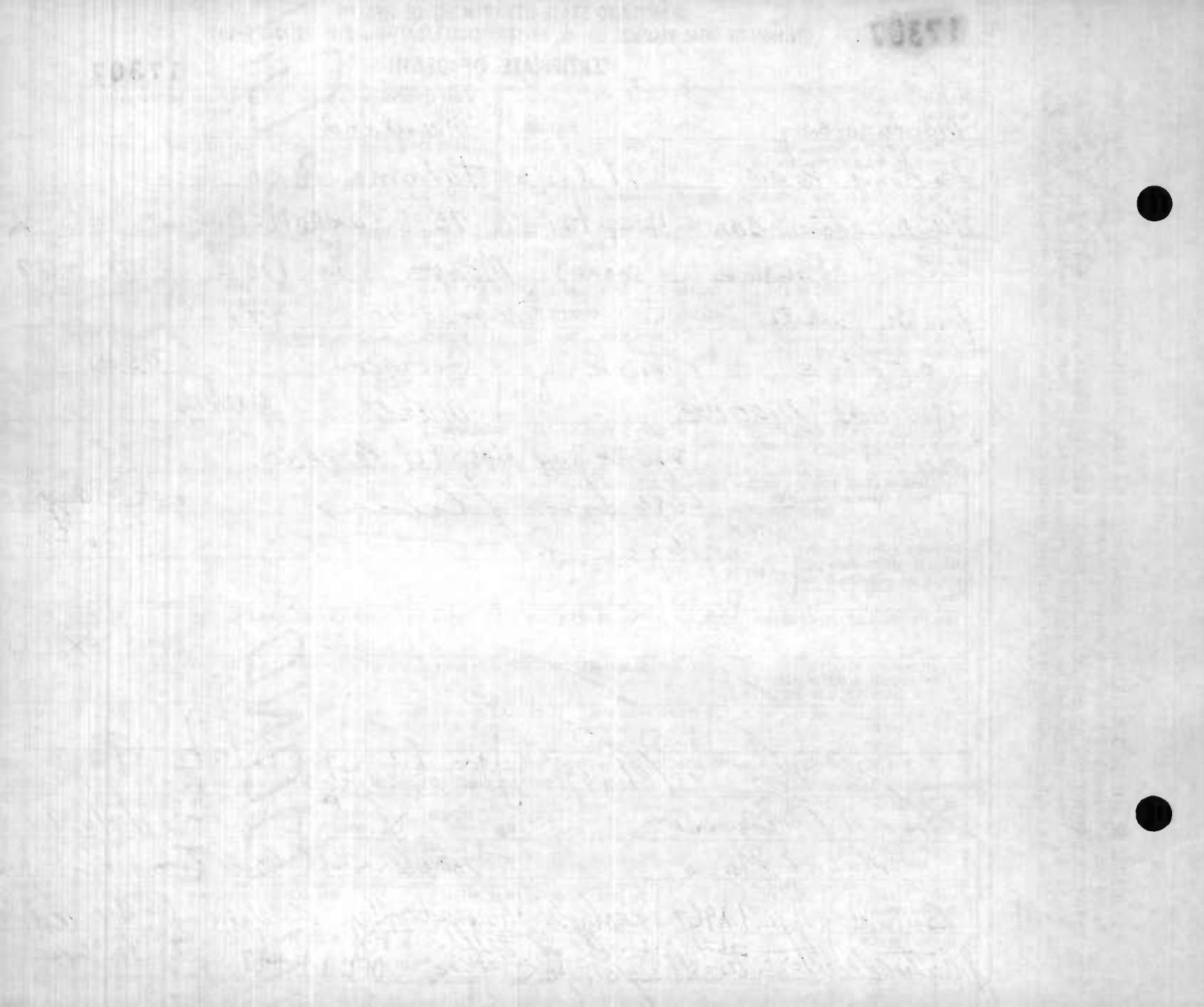
CERTIFICATE OF DEATH

17307

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **Page 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> MONT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>71 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washingtonian San + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Pauline</u>	Middle <u>(none)</u>	Last <u>Moore</u>
4. DATE OF DEATH <u>DEC. 7 1967</u>	Month Doy Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <u>9-28-90</u>	9. AGE (In years lost birthday) <u>77 yrs.</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLISHING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Moore</u>		14. MOTHER'S MAIDEN NAME <u>Martha Barker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-8744</u>	
17. INFORMANT <u>Hospital Records.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5810</u> DUE TO <u>Loss of liver</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteria</u> ONSET AND DEATH (c) <u></u> 3 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <u>203 Carroll Ave Takoma Park MD</u>
20f. (City or town) <u>Takoma Park</u> (County) <u>Adelphi</u> (State) <u>Md.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 22, 1967</u> to <u>Dec 7, 1967</u> that (I) (we) last saw the deceased alive on <u>12/6/67</u> 1967, and that death occurred at <u>203 Carroll Ave Takoma Park MD</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>Howard T Moore</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard T Moore</u>		22d. ADDRESS <u>203 Carroll Ave Takoma Park MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>George Washington Cemetery</u>
24. FUNERAL DIRECTOR <u>Artie DeLattes Washington DC</u>		25a. ADDRESS <u>254 Carroll St. NW</u>	25d. LOCATION (City or Town) (County) (State) <u>Adelphi Prince George's Md.</u>
		25b. DATE <u>Dec 11, 1967</u>	25c. REG'D BY REGISTRAR <u>Charles Judge</u>
		25d. DATE <u>Dec 11, 1967</u>	25e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

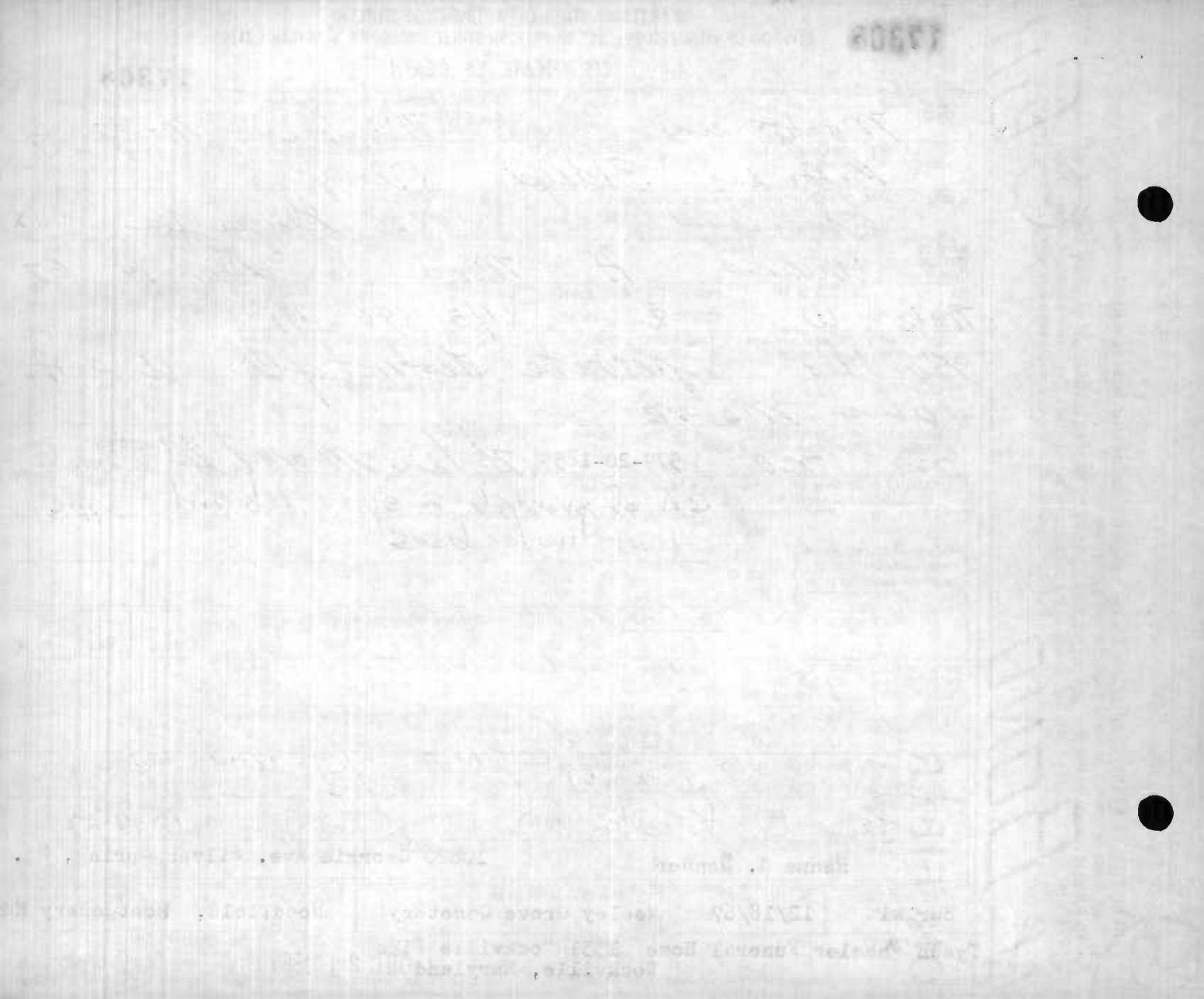
17308

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		
<i>Montgomery</i> <i>Maryland</i>		<i>Maryland</i> <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY		
<i>Bethesda</i>	<i>31 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
<i>Suburban</i>		<i>18825 Georgia Ave</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
<i>William</i>	<i>A</i>	<i>Moore</i>	<i>Dec 14 1967</i>	
4. DATE OF DEATH	Month	Day	Year	
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	
<i>Male</i>	<i>W</i>		<i>1/3/1896</i>	
9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	
<i>71 yrs.</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
<i>Business</i>	<i>private</i>	<i>District of Co.</i>	<i>U.S.A.</i>	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address		
<i>John Moore</i>	<i>Helen Moore / same</i>	<i>as above.</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	INTERVAL BETWEEN ONSET AND DEATH
<i>No</i>	<i>579-20-1855</i>	<i>Helen Moore / same</i>	<i>CA of prostate &amp; spine, rib and liver metastases</i>	<i>3 yrs</i>
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.	DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19				
21. I certify that (I) (this hospital) attended the deceased from <i>11-13 1967</i> to <i>12-14 1967</i> , that (I) (we) last saw the deceased alive on <i>12-13 1967</i> , and that death occurred at <i>1131 Rockville Pike</i> , fram causes and on the date stated above.	22b. DATE SIGNED <i>12-14-67</i>			
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS <i>10820 Georgia Ave. Silver Spring, Md.</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
<i>Benna G. Bender MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City or Town)	(County) (State)
<i>Burial</i>	<i>12/18/67</i>	<i>Wesley Grove Cemetery</i>	<i>Woodfield</i>	<i>Montgomery Md</i>
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
<i>Tyson "heeler Funeral Home</i>	<i>1331 Rockville Pike</i>		<i>DEC 21 1967</i>	<i>Charles Judge</i>
VR A15 (4) 25M 1/67				

8067

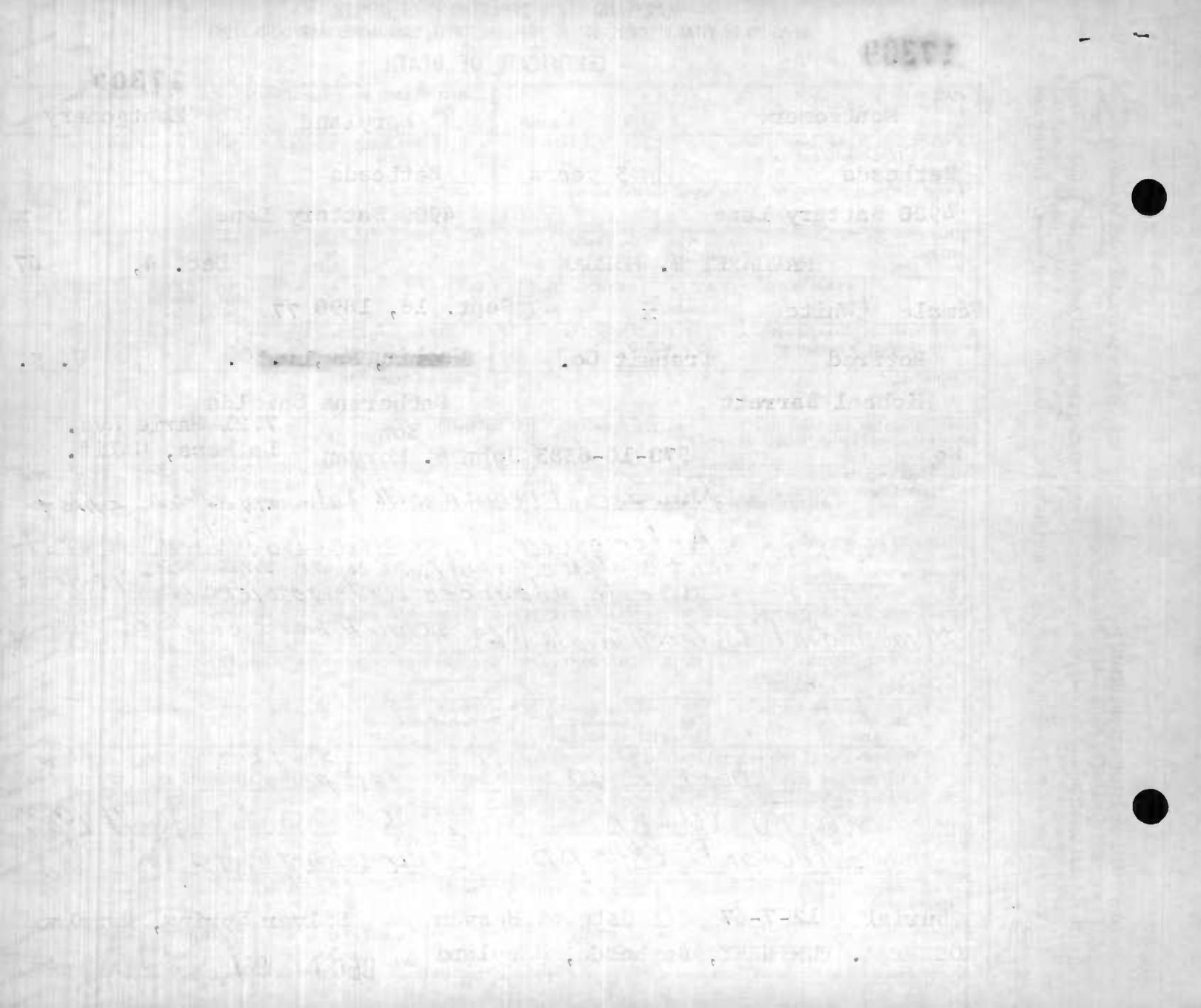


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

17309		17309	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>3 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4900 Battery Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARET B. MORGAN</b>		First	Middle
4. DATE OF DEATH <b>Dec. 4, 1967</b>		Last	Month
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Sept. 16, 1890</b>		9. AGE (In years last birthday) yrs. <b>77</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transit Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>
13. FATHER'S NAME <b>Michael Barrett</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-10-6383</b>	17. INFORMANT Son <b>John B. Morgan</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Decomp. with pulmonary edema</b> DUE TO <b>Very</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b></span>		(b) <b>Arteriosclerosis, generalised advanced.</b> DUE TO <b>and multiple cerebrovascular thromboses</b> <span style="float: right;"><b>10 yrs</b></span>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b>		(c) <b>due to advanced arteriosclerosis</b> <span style="float: right;"><b>10 yrs</b></span>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardial Infarction, old 1963</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4740 Chevy Chase Dr</b>
20f. (City or town) <b>D.C.</b> (County) <b>Charlottesville</b> (State) <b>VA</b>		22b. DATE SIGNED <b>Dec 4 1967</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , to <b>12-4-1967</b> , that (I) (we) lost saw the deceased alive on <b>Dec 1 1967</b> , and that death occurred at <b>10 P.M.</b> from causes and on the date stated above.		22a. SIGNATURE <b>Stewart Clapp</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Silver Spring, Maryland</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-7-67</b>	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
ADDRESS <b>Gate of Heaven</b>		25a. REC'D BY REGISTRAR <b>Charles George</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles George</b>	



17310

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>		c. LENGTH OF STAY IN 1b	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <b>SEAT PLEASANT</b> <b>712 Rollins Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNIVERSITY NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>BRYANT</b>	Last <b>MORRISON</b>
4. DATE OF DEATH	Month <b>DECEMBER</b>	Day <b>5</b>	Year <b>1967</b>
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 9, 1886</b>
9. AGE (In years last birthday) <b>81 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NURSERY</b>	11. BIRTHPLACE (County & State, or foreign country) <b>IOWA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>JOHN E MORRISON</b>		
14. MOTHER'S MAIDEN NAME <b>MARY BRYANT</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		
16. SOCIAL SECURITY NO.	17. INFORMANT	Address <b>EVELYN HEFLIN 407 ROLLINS AVE. SEAT PLEASANT</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <i>Arteriosclerotic Cards -</i> DUE TO <b>Vascular Neural disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 years</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1967</b> to <b>Dec 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 5, 1967</b> , and that death occurred at <b>5:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Wilhelm Bratton</b>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/15/67</b>
22c. PHYSICIAN'S NAME (Type) <b>W M BRATTON</b>	22d. ADDRESS <b>6124 Central Ave, Capitol Hts Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/8/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>WASHINGTON NAT. CEMETERY SUITLAND</b>	23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, PRINCE GEORGES Md.</b>
24. FUNERAL DIRECTOR <b>ROBERT E. WILHELM FUNERAL HOME</b> <b>4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	DATE <b>DEC 11 1967</b> <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17311

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>10 SADDLE ROCK Ct</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Phillip</b>		First <b>Phillip</b>	Middle <b>O.</b>
3. NAME OF DECEASED (Type or print)		Lost <b>MORRISON</b>	4. DATE OF DEATH <b>12 5 1967</b>
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>5/2/09</b>		9. AGE (In years last birthday) <b>59 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Couptroller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Morrison</b>		14. MOTHER'S MAIDEN NAME <b>Leah Eisler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unk.</b>		16. SOCIAL SECURITY NO. <b>069-01-6574</b>	
17. INFORMANT <b>Mrs. ANNE MORRISON (w)</b>		Address <b>10 Saddle Rock Ct. S.S. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO <b>Heart failure - Atherosclerotic HT As.</b> DUE TO <b>Coronary atherosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Gout, Diabetes, mellitus, anemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5 Da</b>
20f. (City or town) <b>1967</b>		(County) <b>1967</b> (State) <b>5 Da</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1</b> , 1967 to <b>5 Da</b> , 1967, that (I) (we) last saw the deceased alive on <b>12/14</b> , 1967, and that death occurred at <b>11 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>12/5/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ira N. Tublin</b>		22d. ADDRESS <b>800 Pershing Dr. S. S. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-6-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>King David New Garden</b>
23d. LOCATION (City or Town) <b>Falls church, Virginia</b>		(County) <b>Falls church</b> (State) <b>Virginia</b>	
24. FUNERAL DIRECTOR <b>Bernard Danzansky + Sons</b>		ADDRESS <b>3501/4 4th St. N.W.</b>	25a. REC'D BY REGISTRAR <b>DEC 6 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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FOR STATE  
HEALTH DEPT.

Any delay is  
any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page  
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17312 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17312

1. DECEASED NAME (Type or Print)	First Cora	Middle Edna	Last Mowry	2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month Dec	Day 31	Year 67 19	2b. HOUR 9P M	
3. SEX Female	4. RACE White	S. DATE OF BIRTH 28 Feb 1877	6. AGE (in years last birthday) 90RS	IF UNDER 1 YEAR MONTHS WIDOWED <input checked="" type="checkbox"/>	IF UNDER 24 HRS. DAYS DIVORCED <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month Day Year 19			
7a. BIRTHPLACE (State or foreign country) Mich		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARKED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MS Md		13c. CITY OR TOWN Montgomery		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10217 Summit Ave			
14. FATHER'S NAME Francis		First E	Middle Hadley	Last Mary	15. MOTHER'S MAIDEN NAME Foster				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-56-3079		17. INFORMANT Ruth M Woolley		ADDRESS 10217 Summit Ave			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))          PART I. DEATH WAS CAUSED BY:          IMMEDIATE CAUSE (a) <u>Pneumonia, Bilat.</u>          DUE TO, OR AS A CONSEQUENCE OF          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____          DUE TO, OR AS A CONSEQUENCE OF          (c) _____</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>									
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 6 1968		23c. NAME OF CEMETERY OR CREMATORIAL Wixon Cemetery		23d. LOCATION (City or Town) Wixon		(County) Mich	(State)
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md		25a. REC'D BY REGISTRAR DATE JAN 5 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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17313

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17313

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) Theresa Catherine Mulholland				2a. DATE OF DEATH Dec 29 <sup>th</sup> Month Day Year 1967	2b. HOUR M
3. SEX Female		4. RACE White	S. DATE OF BIRTH June 11-1899	6. AGE (In years last birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) Penn		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Boyd's Rural		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife	
13a. USUAL RESIDENCE (Where deceased admission) STATE Turtle Creek		13b. COUNTY		13c. CITY OR TOWN JEMIN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME John Hickey		15. MOTHER'S MAIDEN NAME Catherine Gorman		12b. KIND OF BUSINESS OR INDUSTRY Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address John Mulholland. Boyd's (Rural) Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> (metastatic) APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <i>one year?</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Carcinoma of Stomach</i> 1/2 year? DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 15, 1967</i> , to <i>Dec. 29, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec. 29, 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. — <i>10:45 p.m.</i>					
22b. SIGNATURE <i>Jack Schumacher</i>		DEGREE	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>12-30-67</i>	
22d. PHYSICIAN'S NAME (Type) Jack Schumacher Md.		22e. ADDRESS Gaithersburg. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial &		23b. DATE 1-2-68	23c. NAME OF CEMETERY OR CREMATORIAL Braddock Catholic	23d. LOCATION (City or Town) (County) (State) North Braddock Ala. Penn	
24. FUNERAL DIRECTOR Ernest C. Gartner		ADDRESS <i>Ernest C. Gartner</i>	25a. RECD BY REGISTRAR DATE 1/11/1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

8167

FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

*Titian 8 D.O.B. Sept. 1, 1924 - 43 yrs.*

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17314

17314

1. PLACE OF DEATH a. COUNTY <i>Baltimore Md.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rosemont Md.</i>		c. LENGTH OF STAY IN lb <i>2 hrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburbia.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glenelg Md</i>	
d. STREET ADDRESS <i>4806 Scarsdale Rd</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Edgar Murdoch Jr.</i>		First <i>J</i>	Middle <i>E</i>
4. SEX <i>M</i>		5. COLOR OR RACE <i>White</i>	6. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF DEATH <i>Sept 1 1967</i>		8. DATE OF BIRTH <i>1897 1924</i>	
9. AGE (in years from birthday) yrs. <i>70</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cameraman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>John Edgar Murdoch Jr.</i>	
10c. BIRTHPLACE (State or foreign country) <i>Frederick Md</i>		11. CITIZEN OF WHAT COUNTRY <i>USA</i>	
12. FATHER'S NAME <i>John Edgar Sr.</i>		13. MOTHER'S MAIDEN NAME <i>Hannah Sera Lynch</i>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) <i>No</i>		15. IF YES, GIVE WAR OR DATES OF SERVICE <i>1942-1948</i>	
16. IMMEDIATE CAUSE (o) PART I. DEATH WAS CAUSED BY: <i>Multiple Injuries Severe</i>		17. INFORMANT <i>Sam</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Multiple Injuries Severe</i>		19. INTERVAL BETWEEN INJURY AND DEATH <i>2 1/2 hr.</i>	
20. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (o), STATING THE UNDERLYING CAUSE LAST <i>Trauma from Auto Accident</i>		21. DUE TO (b) <i>Trauma from Auto Accident</i> DUE TO (c)	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Had epileptic seizure while driving</i>			
23. MEDICAL CERTIFICATION PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Had epileptic seizure while driving</i>	
25. TIME OF INJURY Month, Day, Year <i>2:00 p.m. 12/30 1967</i>		26. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		28. (City or town) (County) (State) <i>Bethesda Montgomery Md.</i>	
29. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
30. ACTUAL SIGNATURE <i>John G. Ball</i>		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball, M.D.</i>		32. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
33. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		34. DATE SIGNED <i>12/31/67</i>	
35. ADDRESS (Street, city, town, or county) <i>Address</i>			
36. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		37. DATE THEREOF <i>1/3/68</i>	
38. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cem.</i>		39. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>	
40. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., Wash., D. C.</i>		41. ADDRESS <i>ADDRESS</i>	
42. REC'D BY REGISTRAR <i>Charles Judge</i>		43. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

11557

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

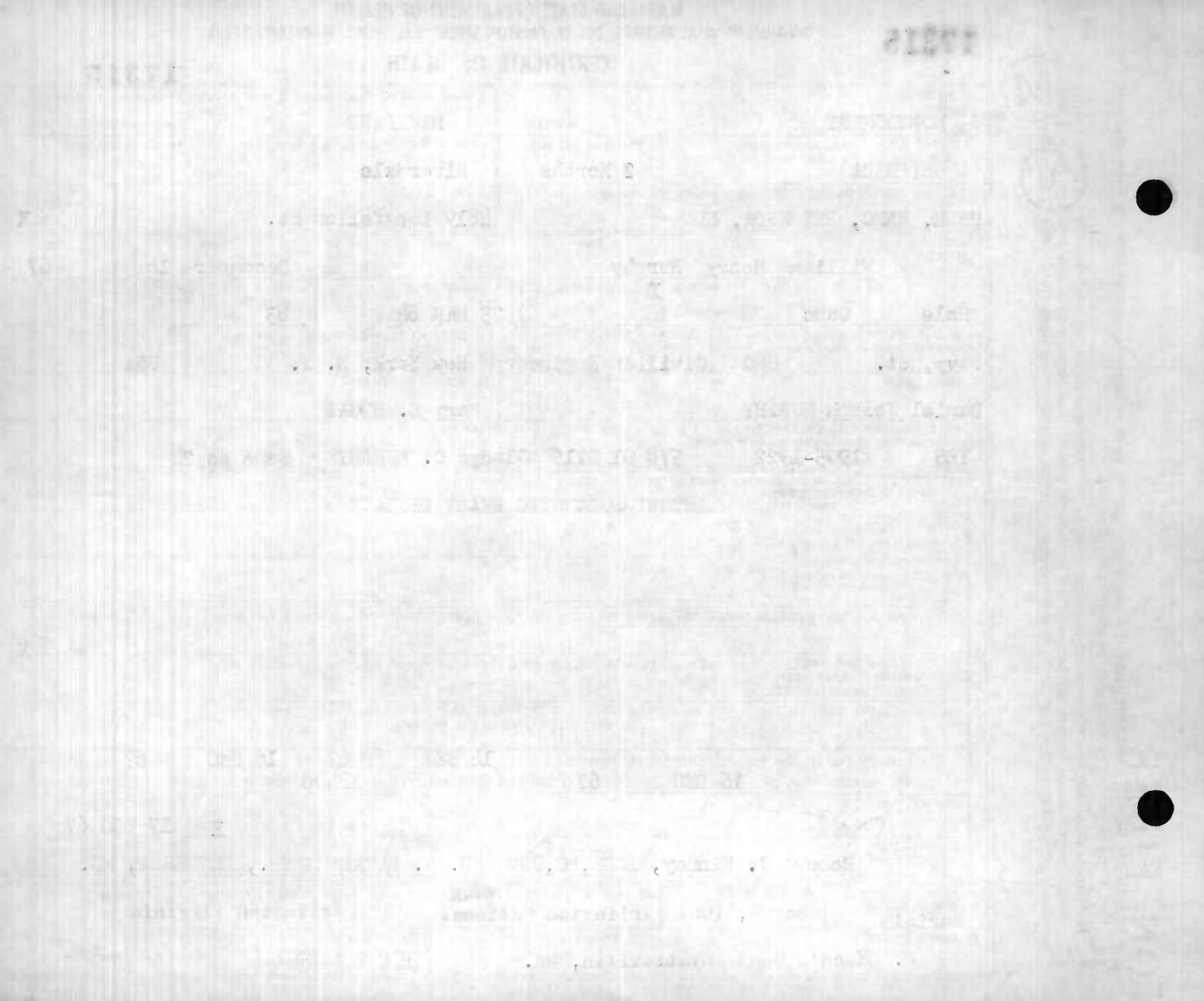
CERTIFICATE OF DEATH

17315

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN lb <b>2 Months</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Pri... County</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USNH, NNMC, BETHESDA, MD</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			
						d. STREET ADDRESS <b>4819 Longfellow St.</b>			
3. NAME OF DECEASED (Type or print)		First <b>William Henry Murphy</b>		Middle 		4. DATE OF DEATH <b>December 16</b>		Month Doy Year 19 67	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 MAR 84</b>		9. AGE (In years last birthday) <b>83 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Navy, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GMC Civilian Engineer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Daniel Joseph MURPHY</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. HOGAN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1905-1922 578 01 0219</b>		17. INFORMANT <b>Gladys C. MURPHY</b>		Address <b>Same as 2d</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>								INTERVAL BETWEEN ONSET AND DEATH	
4200 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.		DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>14 SEP 1967</b> , to <b>16 DEC 1967</b> , that (I) (we) last saw the deceased alive on <b>16 DEC 1967</b> , and that death occurred at <b>1840 N</b> , fram causes and on the date stated above.									
22a. SIGNATURE <i>Robert J. Kirney</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>17 DEC 67</b>					
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Kirney, LCDR, MC, USN</b>		22d. ADDRESS <b>U. S. NAVAL HOSP., BETHESDA, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 20, 1967</b>		23c. NAME OF CEMETERY OR Crematory <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 21 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17316 17894

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First</b> <b>ETHEL</b> <b>Middle</b> <b>WRIGHT</b> <b>Last</b> <b>MUSGROVE</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>1967</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/03</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Name</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter G. Wright</b>		14. MOTHER'S MAIDEN NAME <b>Anna Duvall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Medical Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION</b> INTERVAL BETWEEN ONSET AND DEATH <b>60 DAYS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>GENERALIZED METASTASIS</b> MONTHS <b>1 Month</b>			
stating the underlying cause (c) <b>CARCINOMA BREAST.</b> <b>20 Month</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CARCINOMA ENDOMETRIUM -</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Aug 1964 to 12/29/67</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1964</b> to <b>12/29/67</b> , 1967, that (II) (we) last saw the deceased alive on <b>12/28/67</b> , and that death occurred at <b>11:45 AM</b> . causes and on the date stated above.		20f. (City or town) <b>Burtonsville</b> (County) <b>Montgomery</b> (State) <b>Md.</b>	
22a. SIGNATURE <b>Donald R. Lewis</b>		22b. DATE SIGNED <b>12/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald R. Lewis, M.D.</b>		22d. ADDRESS <b>700 Cloverly St.</b> <b>Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-1-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Union Cemetery</b>
24. FUNERAL DIRECTOR <b>De Witt Donedson, Laurel, Md.</b>		ADDRESS <b>Laurel, Md.</b>	25a. REC'D BY REGISTRAR <b>JAN 12 1968</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 12 Film G390 1/3/68 kk

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CERTIFICATE OF DEATH

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~~TO HOSPITAL OR ATTENDING PHYSICIAN:~~ The law requires that the death certificate be executed within 24 hours after death.  
~~Page 4 may be retained by the hospital or attending physician.~~

~~TO FUNERAL DIRECTOR:~~ After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Montgomery MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARNOLD		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Rosa		L	Musso
4. DATE OF DEATH		Month	Day Year
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		12	24 1967
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F		W	B. DATE OF BIRTH 9/8/53
9. AGE (In years lost birthday)		11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
84 yrs.		Sicily	Italy
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Salvatore Di Pietro		Concetta Giglio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
16. SOCIAL SECURITY NO.		17. INFORMANT	
		Mr. Joseph DiPietro Shore Acres, Md.	
Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
CARCINOMA 180X DUE TO		3 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c), lost.		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
BILATERAL LOBULAR PNEUMONIA			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/21, 1967, to 12/24, 1967, that (I) (we) last saw the deceased alive on 12/24, 1967, and that death occurred at 11 AM, from causes and on the date stated above.			
22. SIGNATURE		22b. DATE SIGNED Richard H. Pollen 12/26/67	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
RICHARD H. POLLON MD		22d. ADDRESS 10400 CONNECTICUT AV KENSINGTON MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/67	
		23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.	
24. FUNERAL DIRECTOR Witzke		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
		ADDRESS D. - 4101 Edmondson Ave.	
		25a. REC'D BY REGISTRAR DEC 26 1967	
		25b. REGISTRAR'S SIGNATURE DATE	

